

**FACTORS THAT MOTIVATE YOUNG PEOPLE AGED 14 – 25 YEARS TO GO FOR
VOLUNTARY COUNSELING AND TESTING FOR HIV IN MALAWI**

By

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DECLARATION

I declare that A STUDY ON FACTORS THAT MOTIVATE YOUNG PEOPLE AGED 14-25 YEARS TO GO FOR VOLUNTARY COUNSELLING AND TESTING FOR HIV IN MALAWI is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



JOYCE CAROLINE MPHAYA (Ms)

31 MARCH, 2006

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ABSTRACT

The study sought to identify factors motivating young people aged 14–25 years to use voluntary counseling and testing (VCT) for HIV in Malawi by interviewing 145 young people. The study identified barriers affecting and strategies promoting young people's access to VCT.

The research results indicate that young people go for VCT mainly to know their HIV status. The availability of VCT services, and the provision of VCT services by peers motivate young people to access VCT. Some young people do not access VCT services due to fears of being found HIV+ve and because of the poor attitudes of the health service providers. Providing more information about VCT, involving young people as VCT providers, using youth friendly health service providers, providing VCT in a separate room for young people and through mobile services will increase young people's access to VCT services in Malawi.

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CHAPTER 1

INTRODUCTION AND BACKGROUND INFORMATION

1.1 INTRODUCTION

Today's youth is the largest in history with nearly half of the global population being younger than 25 years of age (UNAIDS 2004:93). They have not known a world without AIDS. Young people are both the most threatened, globally, accounting for half of the new cases of HIV, and the greatest hope for turning the tide against AIDS (UNAIDS 2004:93). The future of the epidemic will be shaped by their actions.

Many approaches to HIV prevention, treatment and care require that people know their HIV status. The importance of Voluntary Counselling and Testing (VCT) for HIV has brought about the wider promotion and development of VCT services. However, since the majority of places where HIV has a major impact are also the poorest, the lack of resources has meant that VCT is still not widely available (UNAIDS 2001:7). In Malawi, VCT services are still minimal but in the process of being scaled up. At least every district has more than one VCT site which is an improvement on previously non-available VCT sites. Studies conducted in Malawi have shown that in the year 2000, 86,0% of the adolescent males wanted to know their HIV status but only 7,0% had gone for testing (Munthali, Chimbiri & Zulu 2004:27). On the other hand, studies on young

females in Malawi have revealed that 72,0% of them knew where to go for VCT but only 9,0% had gone for testing (UNICEF, UNAIDS & WHO 2002:47).

This study therefore examined factors that motivate young people aged 14–25 years old to go for VCT in Malawi since this is the age group that can contribute to the reduction of HIV as many of them might not yet be infected.

1.2 BACKGROUND INFORMATION

VCT is an important tool for preventing infection and it allows young people to evaluate their behaviours and the consequences thereof. A negative test offers a key opportunity to reinforce the importance of safety and risk reduction behaviours. Knowledge of HIV status is the gateway to behavioural change, treatment, care, support and has documented prevention benefits. However, the current reach of HIV testing services is poor and the uptake is low largely because of fears of stigma and discrimination (UNAIDS 2004:85). It has been documented that young people do actively seek and receive VCT in several sub Saharan African (SSA) countries such as Uganda, even though the available VCT services were not designed specifically for young people (McCauley 2004:8).

In many developing countries, VCT has not been available to young people. However, when young people were asked whether they would like to be tested,

they often said they would like VCT to be widely available and would like to be tested (Boswell & Baggaley 2002:1). Studies conducted among university students in Zambia and in the United Kingdom (UK) revealed that 35,0% and 15,0% of the students in these respective countries said they would like to get tested. However, only 10,0% of Zambian and 7,0% of UK students had actually gone for HIV testing (Baggaley 1997:91). In another study conducted in Zimbabwe, 37,0% of the participants expressed their willingness to be tested and these were given instructions of when and where to go for testing. However, only 9,0% of this group actually went for testing (Fylkesnes, Haworth, Rosenvard & Kwapa 1999:2471). This shows that there are still some factors that are affecting young people's access to VCT. Some of the reasons cited by young people for not going for VCT include fear of being found HIV positive, fear of losing a relationship, lack of confidentiality, being sexually inactive, and using condoms consistently (Munthali et al 2004:27).

The overall picture of VCT for HIV in Malawi can best be understood in the context of current knowledge about HIV prevalence, government policy towards HIV prevention, care and treatment of those infected, government and private sector efforts to combat HIV transmission and options for VCT services (Yoder & Matinga 2004:3). Counselling and testing have also been integrated as one of the priority components in the Malawi National HIV/AIDS Policy (NAC 2003:12). Many organisations both public and private, have been seeking ways to support the implementation of an HIV framework. Some groups have advocated for the

establishment of stand alone centres or hospital based VCT centres. So far in Malawi, there are 289 sites providing VCT services with 16 of these sites being stand alone services (MoH 2004a:3).

However, studies conducted in Malawi among young people showed that 87,0% of young people knew where they could go for VCT and 76,0% indicated that they would like to be tested but only 18,0% had gone for testing (Maluwa & Kawala 2003:7). The reasons established for not going for testing are mostly stigma and discrimination. Very little data on how and why young people come for HIV testing in Malawi are currently available. A study by Umoyo Network in Malawi showed that 54,0% of the sample indicated that illness motivated them to be tested and yet, most of the young people that were going for testing were not sick (Yoder & Matinga, 2004:5). It was therefore recommended in the study by Yoder and Matinga (2004:5) that a better understanding of what brings people for testing would be useful for planning the expansion of testing and/or VCT centres. It was also recommended by Munthali et al (2004:39) that further studies need to be done in order to determine factors that would help promote the uptake of VCT services by young people.

It is therefore against this background that the researcher proposed a study on factors that motivate young people aged 14-25 years to go for VCT targeting young people who had actually gone for HIV testing. Their reasons for and experiences of going through the VCT process could be used to motivate other

young people to go for VCT if implemented in future policies. Emphasis is put on young people because, according to UNICEF, UNAIDS and the WHO (2002:5) global success in combating HIV/AIDS must be measured by its impact on children and young people.

1.3 RESEARCH PROBLEM

VCT is based on the principle that tested clients who are HIV negative should receive counselling to identify and reduce high risk behaviours. Those who test HIV positive should be helped to get proper clinical care, support services and counselling to reduce the chances of transmitting HIV. Malawi's Demographic and Health Survey 2004 has revealed that only four percent of girls and seven percent of boys aged 14 – 25 years have gone for testing in Malawi (National Statistical Office 2005:26). Factors that affect access to the services by young people include a range of situational, interpersonal and structural limitations such as knowledge about AIDS, behavioural intentions, perceived susceptibility, perceived barriers, self efficacy and demographic factors.

VCT services are available at 289 sites in Malawi yet only a few young people have accessed these services. Much information on factors that hinder young people's access to VCT exists based on studies that were conducted among the majority of young people who had not gone for VCT. As such, behavioural change programmes have been developed based on this information and yet

there is still no great improvement in the number of young people accessing these services. There is little information about factors that motivated young people, who had gone for HIV testing, to do so. Young people who went for testing could use their experiences of going through the whole process of making the decision to get tested and accessing the services to provide information about the system, processes and environment and to motivate other young people to go for VCT.

1.4 RESEARCH QUESTIONS

To facilitate the collection of the information that would contribute towards understanding why young people go for HIV testing, the following research questions need to be answered:

- What are the reasons why young people are going for VCT in Malawi?
- What are some of the factors that are hindering young people's access to VCT in Malawi?
- What could be done to ensure that more young people access VCT in Malawi?

These research questions will be answered in relation to the Health Belief Model's (HBM's) concepts of individual perceptions of susceptibility, perceived benefits, perceived barriers and cues to action (ReCAPP 2005:2). The HBM will be discussed in chapter 2.

1.5 PURPOSE OF THE RESEARCH

The main purpose of the study is to explore and describe factors that motivate young people aged 14 – 25 years to access VCT services in Malawi. Factors hindering access to VCT services in Malawi will also be identified and described. This information will be used to recommend ways in which VCT services in Malawi could become more accessible to more young people aged 14-25 years.

1.6 RESEARCH OBJECTIVES

The research objectives guiding this study, aimed to:

- determine reasons why young people go for VCT in Malawi
- identify possible barriers experienced by young people in accessing VCT services in Malawi
- identify strategies that would promote VCT access by young people in Malawi.

1.7 ASSUMPTIONS UNDERLYING THE STUDY

Assumptions are basic principles that are accepted on faith or assumed to be true, without proof or verification (Polit & Hungler 1999:640). This research is

based on the assumption that most young people should realise the need to go for VCT in order to take the necessary precautions. It is also assumed that young people might not be sexually active hence they might be at a lower risk of getting HIV, making it easier for them to go for VCT, than it would be for sexually active older persons.

1.8 SIGNIFICANCE OF THE STUDY

The most definitive measure of VCT's effectiveness in reducing HIV transmission is the rate of new infections diagnosed in people who utilised VCT services. Most interventions addressing young people's access to VCT are based on the assumption that young people encounter barriers to accessing VCT, hence they need to deal with those barriers. However, it is important to draw on the experience of the young people who have gone through the process of VCT and to develop programmes that will deal with the real issues and aim at sustaining the motivating factors.

Knowledge gained from the study will be particularly useful for policy makers. The results will assist policy makers to come up with policies that will be conducive to attracting more young people to access VCT.

The results will also help training institutions for health service providers to incorporate the findings in their training curriculum. This will ensure that all service providers are aware of issues related to young people.

Knowledge gained from the study will be particularly useful for community health nurses in Malawi as it will enable them to target and understand the needs of young people as it relates to VCT.

Findings from the study will also be an essential step in the development and implementation of programmes that will encourage more young people to go for VCT. The findings will also be beneficial to organisations that have an interest in promoting VCT access to young people.

The findings might contribute to behavioural changes among young people by emphasising the positive reasons why young people should go for VCT.

1.9 ETHICAL CONSIDERATIONS

The protection of the rights of human subjects has become high priority among members of scientific and health care communities (Polit & Hungler 1999:29). As such, researchers need to exercise care that the rights of individuals and institutions are safeguarded. In this research, ethical issues were taken into consideration especially realising that VCT is a sensitive issue and that HIV is a human rights issue. Ethical principles that were considered were the principles of beneficence, respect for human dignity and justice.

1.9.1 Principle of beneficence

This principle encompasses the maxim of above all do no harm (Polit & Hungler 1999:31). The principle has multiple dimensions which are freedom from harm, freedom from exploitation, benefits of research and risk/benefit ratio. These dimensions were considered in this study by ensuring that the participants know the benefits of the study and have full details about the study. In addition, a good relationship was developed between the researcher and the participants to enhance reciprocal trust.

1.9.2 Principle of respect for human dignity

This principle ensures that the right to self determination and the right to full disclosure are respected (Polit & Hungler 1999:33). This was ensured in this study by providing all the necessary information about the study to the participants and no person was forced to participate in the study.

1.9.3 Principle of justice

This principle includes the subject's right to fair treatment and right to privacy (Polit & Hungler 1999:35). These rights were fulfilled in this study by ensuring that no identifying information was collected from the participants for anonymity

purposes. In addition, confidentiality was ensured throughout the entire research process. More details on ethical considerations will be discussed in chapter three.

1.10 SCOPE AND LIMITATIONS OF THE STUDY

This study was conducted in the catchment areas of three facilities offering VCT services and these were Chitipa District Hospital, Kamphata Youth Centre and Bangwe Health Centre. Chitipa District is a rural district situated in the northern region of Malawi, Kamphata Youth Centre is situated in the central region of Malawi in Lilongwe District which is the Capital City of Malawi and is a stand alone site that provides VCT services while Bangwe Health Centre is situated in the peri urban area of Blantyre City which is in the southern region of Malawi (see Annexure A: map of Malawi indicating the study sites).

Some limitations were expected in this study, including the fact that the respondents were people who had been tested for HIV and some were HIV positive. These young persons might be sensitive to the study and some may either provide wrong information or refuse to participate. In addition, the number of females that access VCT in Malawi is smaller than the number of males who do so. This may lead to having fewer tested females, compared to males, who might participate in the study.

1.11 DEFINITIONS OF TERMS USED IN THE RESEARCH REPORT

The following terms are used repeatedly throughout this dissertation. Therefore the terms are defined and/or explained as intended by the researcher so that the readers and the researcher can approach this report sharing similar concepts about the following terms.

Integrated counselling and testing (CT) services: These are CT services being offered at sites which are incorporated into health facilities with the CT services being directly linked to health services delivered by the facility (MoH 2004b:9)

Post Test Club (PTC): A post test club is a club for people who have had an HIV test regardless of their status and aims to provide support to individuals and communities dealing with HIV/AIDS (Liverpool School of Tropical Medicine 2001:3)

Stand alone CT sites: These are CT services offered at sites located outside of a health facility and not directly linked to other health services (MoH 2004b:9).

Voluntary Counselling and Testing (VCT): It is a process whereby an individual or couple undergo counselling to enable them to make an informed choice about being tested for HIV (Boswell & Baggaley 2002:1).

Young people: According to the Malawi National Youth Policy (1996), youth are defined as those people aged 14–25 years, married or unmarried, with or without children. According to the WHO, a young person is defined as any one aged between 10 and 24 years while an adolescent is defined as anyone aged between 10 and 19 years. For the purpose of this research, the term young people will be used to cover people aged 14-25 years as defined by the Malawi Youth Policy and the term young people will be used interchangeably with youth.

1.12 LIST OF ABBREVIATIONS

A number of abbreviations appear repeatedly throughout this dissertation. The first time the full term will be given followed by the abbreviation. Thereafter only the abbreviation will be used. In order to assist readers to trace any abbreviation's full term the following list of abbreviations used throughout this dissertation is provided.

AIDS	Acquired Immune Deficiency Syndrome
HBM	Health Belief Model
HIV	Human Immuno Deficiency Virus
HIV-ve	Negative; not infected with the Human Immuno Deficiency Virus
HIV+ve	Positive; infected with the Human Immuno Deficiency Virus
IEC	Information, Education and Communication

MACRO	Malawi Counselling and Resource Organisation
MoH	Ministry of Health (of Malawi)
NAC	National AIDS commission
PTC	Post test club
SSA	Sub Saharan Africa
RSA	Republic of South Africa
SRH	Sexual and reproductive health
TBA	Traditional birth attendant
VCT	Voluntary counseling and testing
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
UK	United Kingdom
Unisa	University of South Africa
WHO	World Health Organization

1.13 ORGANISATION OF THE REPORT

The dissertation has been outlined in the following manner:

Chapter one introduced the study and discussed background information relevant to the research, the research problem, aims, objectives, assumptions, operational definitions, ethical considerations, scope and limitations and organisation of the report.

Chapter two discusses the literature review conducted on the HBM and young people's access to and utilisation of VCT.

Chapter three outlines the research methodology used in the study.

Chapter four provides a presentation of data analysis according to the items in the interview schedule

Chapter five provides conclusions, limitations and recommendations for increased access to and utilisation of VCT services by young people in Malawi and to identify areas that may need further research.

1.14 SUMMARY

It has been highlighted in this chapter that motivational factors for young people's access to VCT need systematic analysis and understanding. The current situation on these issues poses critical questions on what knowledge exists among young people regarding VCT, various factors that are motivating young people to go for VCT and strategies that could be put into place to improve the current situation. The purpose, objectives, significance, ethical considerations and the scope as well as the limitations of the study were discussed.

The next chapter will discuss the literature reviewed about the HBM and VCT among young people in different countries. This information will be compared with the situation in Malawi.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter discusses the literature reviewed about VCT among young people. A literature review involves the systematic identification, location, scrutiny and summary of written material that contains information on a specific research problem (Polit & Hungler 1999:645). The purpose of this literature review is to determine the extent to which theory and research have been developed about the studied topic, identify the definition of concepts and variables already established, examine elements of research used by others, such as designs, methods, instruments and techniques of data analysis that may prove useful in the proposed project.

In this study, the purpose of the literature review was to obtain information on VCT knowledge, access and utilisation of VCT services by young people. This information would facilitate the researcher's understanding of the existing situation and identify areas requiring further interventions and investigations. Identification of what is already known in the area of study ensures that the researcher does not duplicate efforts but concentrates on areas that can contribute to new knowledge. The literature reviewed showed that much research has been done on VCT access and utilisation by young people globally, as well

as in Malawi. However, little information on factors motivating young people to access VCT exists. This literature review will therefore be discussed with reference to the Health Belief Model (HBM) which forms the conceptual framework of this study.

2.2 THE HEALTH BELIEF MODEL (HBM)

The HBM is one of the most widely used conceptual frameworks for understanding, explaining and predicting health behaviour (Campus 2005:1). It explains why people fail to practise recommended desirable health behaviour. The HBM explains that the probability that one will engage in a particular undesirable health behaviour is related to one's belief about the seriousness or severity of the potential illness. The HBM has been used to explore a variety of long term and short term health behaviours, including sexual risk behaviours and the prevention of HIV.

The HBM integrates psychological theories of goal setting, decision making and social learning. It postulates that health seeking behaviour is influenced by a person's perception of a threat posed by a health problem and the value associated with actions aimed at reducing the threat (Polit & Hungler 1999:128).

2.2.1 Assumptions of the Health Belief Model

The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the Public Health Services of the United States of America (USA) (Campus 2005:1). These developers formulated several assumptions related to one taking a health related action.

- The HBM assumes that a person will take a health related action if that person feels that a negative health condition can be avoided (Campus 2005:1). It is necessary to help individuals realise that they have the potential to avoid a condition and this can only happen when one is aware of the problem or issue with all details related to it. It is only when one realises this that one would be able to move a step further into action.
- The HBM also assumes that a person will take action if that person has a positive expectation that by taking a recommended action, s/he will avoid a negative health condition (Campus 2005:1). The person needs to see the benefits that s/he will get from practising a behaviour. If a person fails to see any benefit, it would be difficult for him/her to take the necessary action(s), or to continue doing so.
- The HBM further assumes that a person takes a health related action if the person believes that s/he can successfully take the recommended action (Campus 2005:1). It requires the person to feel confident that s/he has the capacity to take the recommended action and this means that

there is a need to ensure that the person has the necessary knowledge and skills in a supportive environment to carry out the required action(s).

The HBM has spelt out constructs representing the perceived threat, net benefits and cues to action. According to ReCAPP (2005:2), these include perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self efficacy.

2.2.1.1 *Perceived Susceptibility*

This explains one's chances of getting a condition. A person's perception that a health problem is personally relevant will contribute to the taking of the required action by the individual. One requires an understanding how any health problem or issue will affect oneself to acknowledge the risk of being affected by the problem. This requires that there should be activities that increase an individual's perception of his/her own vulnerability to a condition.

2.2.1.2 *Perceived severity*

This is one's own opinion about how serious a condition is and what its consequences are. When one recognises one's susceptibility to a certain problem or condition, it does not necessarily motivate one to take the necessary action(s) unless one realises that getting the condition would have serious

physical, psychological and social implications. It is when one realises the magnitude of the negative consequences of a condition, that one could take the necessary action(s) to avoid these negative consequences (ReCAPP 2005:2).

2.2.1.3 *Perceived benefits*

These include one's beliefs in the efficacy of the advised action to reduce the risk or seriousness of impact. The person needs to believe that by taking a certain action, it will help him/her to avoid or prevent a problem from occurring. It is this belief that gives a person confidence to take the action because of the expected outcomes (ReCAPP 2005:2).

2.2.1.4 *Perceived barriers*

This is one's belief in the tangible and psychological costs of the advised behaviour. There could be several barriers that can affect people's decision making to take a particular action. These include costs, duration, complexity of the desired behaviour and accessibility to services that would support taking and maintaining the required action(s) (Polit & Hungler 1999:128). It is only when persons realise that they have the capacity to deal with these barriers that they would be able to take the necessary action(s).

2.2.1.5 Cues to action

These are strategies to activate readiness (ReCAPP 2005:2). This is when an individual feels the desire to take the necessary action after believing that s/he has the capacity. The required action will benefit her/him by knowing how to deal with the expected barriers. It requires motivation on the part of the person to have the desire to comply with a prescribed action or treatment, to have concern about health matters, to be willing to seek and accept health care and to engage in positive health activities (Polit & Hungler 1999:129).

2.2.1.6 Self efficacy

Self efficacy refers to the strength of an individual's belief in his/her own ability to respond to novel or difficult situations and to deal with any associated obstacles or set-backs (Peltzer 2000:39). This is confidence in one's ability to take action. One should feel that one is capable of taking the necessary action correctly because it is that confidence that would motivate one to initiate and sustain the action (ReCAPP 2005:2).

2.3 LITERATURE ON VOLUNTARY COUNSELLING AND TESTING AS IT RELATES TO THE HBM ASSUMPTIONS AND CONSTRUCTS

Literature on VCT shows that there is a relationship of the available data with the assumptions and constructs that have been discussed on HBM. Various aspects of the existing research information show that most of the areas in HBM have been explored in relation to VCT and HIV/AIDS.

2.3.1 The HIV/AIDS situation in Malawi and other countries

AIDS has been with us for over 20 years and it will continue to challenge us for many decades (UNAIDS 2004:7). It is known that unless more is done today and tomorrow, the epidemic will continue. In the UNAIDS report, proof is provided that HIV, if left to run its natural course, will cause devastation on an unprecedented scale. This is evident because the HIV rates are still going up leading to increased deaths of parents and increased orphanhood especially in sub-Saharan Africa (SSA) where 12 million children have lost one or both of their parents to AIDS (UNAIDS 2004:61).

AIDS was first diagnosed in Malawi in 1985 and in that year 17 cases were reported (Yoder & Matinga 2004:3). Malawi now ranks among the countries with the highest prevalence rates in the world with the prevalence rate of 14% (NAC

2005:18). The prevalence rate is not evenly distributed among adults by age and gender. In the age group 15–24, the HIV infection rate of females is twice as high as that of males (UNAIDS 2004:91). This means that HIV continues to be particularly high in adolescent girls who become sexually active at an earlier age than their male counterparts. This trend is seen in SSA where 75,0% of all people infected with HIV are females (UNAIDS 2004:93). In addition, HIV prevalence in Malawi is not spread uniformly across the country. There are clear regional differences in HIV prevalence. It should be noted that HIV rates in Malawi are estimated from antenatal clinic data and the Epi Info computer database is used for data analysis (NAC 2003:14).

The southern region of Malawi has the highest rates of HIV infection (21,7%) among antenatal mothers while the northern region has the lowest (14,0%) HIV prevalence rates (NAC 2005:12). The southern region of Malawi is densely populated and there is a lot of migration of people from the other two regions since there are tea estates where they work as labourers. Blantyre district is Malawi's best known commercial city found in the southern region of the country. More people have settled in Blantyre for employment purposes. Most of the people in Blantyre live in peri-urban areas which are overpopulated and most of them lack access to basic needs including information, services including VCT, food and other resources. Bangwe township is one of these places and this is one of the study sites due to its high population and high HIV rates (see Annexure A: map of Malawi).

The northern region of Malawi is sparsely populated and there are fewer economic activities that would attract people to go there. Most of the people have migrated to the central or southern regions of the country to seek employment. One of the districts in the region is Chitipa which borders Tanzania. This is a district which is sparsely populated and there is a lot of cross border movement. Chitipa is one of the study sites due to its status of being a border district with lower HIV rates (see Annexure A).

The central region of Malawi is also one of the densely populated regions where HIV rates are high. One of the study sites is Lilongwe which is in this region. Lilongwe is the capital city of Malawi and is a government city where all the government and political offices are. Kamphata, which is in Lilongwe, was thus also identified as one of the study sites. The HIV prevalence rates in Lilongwe are as high 18,6% and access to VCT services is limited (NAC 2005:12).

2.3.2 Young people's knowledge, risk perception and access to HIV testing

Knowledge of HIV status is the gateway to behavioural change, treatment, care, support and has documented prevention benefits. In many developing countries, VCT has not been available to young people. Pettifor, Rees, Steffenson, Hlongwa -Madikizela, MacPhail, Vermaak and Kleinschmidt (2004:54) suggested

that in order for young people to take precautions to protect themselves from HIV, they first have to think that they are potentially at risk of becoming infected. In their study conducted among young people aged 15 – 24 in South Africa, 36,0% of young people reported that they believed they were not at risk at all of contracting HIV, 35,0% reported being at small risk while 12,0% at moderate risk and 14,0% at high risk. On the other hand, the same study revealed that 67,0% of the young people reported having had sexual intercourse (Pettifor et al 2004:54). In another study conducted in Malawi in 1994, focus group discussions with primary and secondary school pupils showed that about 79,0% of the young people generally perceived themselves to be at risk of getting HIV (Munthali et al 2004:29). A study conducted three years later in 1997 in Malawi, revealed that only 45,0% of young people felt that they were at risk of contracting HIV. However, 61,0% of the males and 57,0% of the females were reportedly sexually active (Munthali et al 2004:29 & 15). This shows that there might be no increased HIV risk perception among young people who engage in sexual behaviour that could substantially increase their risks of HIV infection.

However, when young people are asked whether they would like to be tested, they often say they would like VCT to be widely available and would like to be tested (Boswell & Baggaley 2002:1). Studies conducted in Kenya and Uganda revealed that young people had strong interests in knowing about their HIV status to the extent that 75,0% of untested young people in Kenya and 90,0% in

Uganda indicated that they would like to be tested in the future (Horizons Programme 2001:13). Of those young people who had an HIV test, 74,0% in Kenya and 84,0% in Uganda indicated that they intended to repeat the test (Horizons Programme 2001:13). Their reasons for going for HIV testing included prevention since they felt that they had some risk of contracting HIV, to plan their lives and to get general medical check-ups to enable them to stay healthy.

Further studies conducted among university students in Zambia and in the UK revealed that 35,0% and 15,0% of the students respectively said they would like to get tested. However, only 10,0% of Zambian and 7,0% of UK students had actually gone for HIV testing (Baggaley 1997:91). In another study conducted in Zimbabwe, 37,0% of the young people expressed their willingness to be tested and these were given instructions of when and where to go for testing. However, only 9,0% of this group actually went for testing (Fylkesnes et al 1999:2471). A study conducted in South Africa also revealed that 60,0% of young people were interested in knowing their HIV status but only 11,0% reported knowing their status (Pettifor et al 2004:56).

Studies conducted in Malawi have shown that in the year 2000, 86,0% of the young males wanted to know their HIV status but only 7,0% had gone for testing (Munthali et al 2004:27). Studies on young females aged 15 -24 in Malawi, revealed that 72,0% of them knew where to go for VCT but only 9,0% had actually gone for testing (UNICEF, UNAIDS & WHO 2002:47). This shows that

risk perception among young people is still low compared to their sexual practices and this explains why most of them are not going for VCT. Some young people have, however, also seen the benefits of getting tested and have taken the steps to do so though they might remain the minority in any community.

It is further reported that some factors contribute to young people's access to VCT services. These include education levels and peer influence. It was indicated by UNICEF, UNAIDS & WHO (2002:32) that increased education leads to increased knowledge of where to go for testing. Studies conducted in several countries have shown that 69,0% of young females aged 12-24, who had secondary and higher education, knew where to get tested compared to 38,0% and 20,0% of those who had primary education and no education respectively (UNICEF, UNAIDS & WHO 2002:32). Peers also play a major role in the testing experience of young people. About 80,0% of young people in Kampala who were tested for HIV, had told their peers about their plans to utilise VCT services prior to doing so (Horizons Programme 2001:24). This provides insight on how influential peers could be in motivating young people to use VCT services.

2.3.3 Perceived benefits for VCT among young people

VCT is an important tool for preventing HIV since it allows young people to evaluate their behaviour and its consequences (UNICEF, UNAIDS & WHO 2002:31). A negative test result offers a key opportunity to reinforce the importance of safety and risk reduction behaviours. Young people who test HIV positive receive referrals for care and opportunities to talk to knowledgeable people who can help them to understand what their HIV status implies.

Studies were conducted in Tanzania, Trinidad and Kenya on VCT efficacy. These research results revealed that there was a significantly greater decline in the proportion of individuals who had unprotected sex with non-primary partners, and HIV infected individuals who reduced their sexual risk behaviours with primary partners, subsequent to utilising VCT services (McCauley 2004:2). In addition, the study showed a 35,0% decrease in unprotected sex among those who were tested compared to 13,0% among those who just got the information on HIV transmission and condom use. Another study, conducted in Nairobi, indicated that most young people said they would adopt safer sexual behaviours after having had an HIV test done (Horizons Programme 2001:13). About 78,0% said that they would decrease the number of sexual partners, 83,0% would

practice monogamy, and 52,0% would use condoms while only 48,0% said they would abstain from all sexual encounters.

However, despite young people mentioning the benefits of VCT, a study conducted in Malawi, Burkina Faso and Uganda revealed that young people mentioned that it might not be good for someone to know his/her HIV status. Some people might intentionally spread the virus for reasons of revenge if they learn they are HIV positive (Amuyunzu-Myamongo, Biddlecom, Ouedraogo & Woog 2005:39). Little is known about the impact of HIV testing on young people as to whether it helps them to make changes in their sexual behaviour, how young people who test HIV+ve cope, with whom they share their HIV test results, who provides emotional support and if they are able to access support services following VCT (Baggaley 2001:35).

A study conducted in Kenya revealed that 95,0% of young people who had been tested, shared their results with someone. About 35,0% shared the results with their peers, 30,0% with their spouses and 25,0% with their siblings (Horizons Programme 2001:26). Fewer than 25,0% told their parents about their test results because they did not want their parents to know that they were sexually active. Others feared their parents reactions, especially those of their mothers, if they were to be HIV+ve.

2.3.4 Perceived barriers to access VCT by young people

The current reach of HIV testing services is poor and uptake is low, largely because of fears of stigma and discrimination (UNAIDS 2004:85). Some other reasons cited by young people for not going for VCT include fear of being HIV positive, fear of losing a relationship, lack of confidentiality, not being sexually active, using condoms consistently (Munthali et al 2004:27). A study conducted in Kenya revealed that there is a perception that testing is for the ill. Those who did not go for testing did not feel at risk of HIV (Horizons Programme 2001:18). Further reasons stated by young people in Uganda for not going for HIV testing include 13,0% cost, 44,0% did not feel at risk and were still thinking about getting tested, 11,0% never had sex. Other reasons for not accessing VCT were fears that people would find out that one went for testing, inconvenient hours of VCT services, distances from services and peer influences.

A study conducted in Zambia indicated that 57,0% of boys and 53,0% of girls said they would like to have an opportunity of going for HIV testing (Baggaley 2001:34). However, the majority of them were not keen to have an HIV test at that time, as they were worried that they might be positive despite HIV prevalence being relatively low in this age group. Another study conducted in Malawi revealed that young people did not access VCT services due to worries about confidentiality and fears that the results would be shared with their parents without the young people's consent (Munthali et al 2004:27). It was further

reported by Amuyumzu-Myamongo et al (2005:39) that one key barrier young people identified in a study conducted in Malawi, Ghana, Burkina Faso and Uganda was the shyness and shame that young people felt when obtaining services like those for sexual and reproductive health (SRH) and VCT. Young people might prefer traditional healers than health care workers, operating within the formal (western) health care system because traditional healers might be perceived to be more discreet.

Boswell and Baggaley (2002:17) indicated the following barriers to VCT for young people:

- Lack of availability and acceptability of VCT services
- Long waiting times
- High cost and pressure by health staff to notify partners
- Worries about confidentiality and fears that results would be shared with parents or partners without their consent
- Inaccurate risk perception
- Fear of being labelled and stigmatised by their families and communities
- Inadequate responses from health care providers, including counsellors, to effectively meet the HIV prevention, care and support needs of young people.

2.3.5 Service delivery issues affecting young people's likelihood to access VCT services

Reaching young people with health services is an important challenge. Young people often do not attend formal health services for their preventive health needs. Instead, they may seek SRH services in a variety of settings. When young people in Zambia were asked where they went for SRH services, 44,0% mentioned traditional healers, 32,0% private clinics and 8,0% mentioned friends (Boswell & Baggaley 2002:7). Another study by Pettifor et al (2004:57), conducted in South Africa, showed that 47,0% of the young people had been to the clinics but only 20,0% of them obtained contraceptives and only 5,0% collected condoms.

Since few young people use health services, using VCT as a strategy to reduce risk behaviours among young people appears to be more challenging than it would be among adults. As such, VCT services may have to be general or targeted depending on a range of factors including HIV prevalence, health seeking behaviours, level of stigma, access to hard to reach groups and supportive legal and policy environments (Boswell & Baggaley 2002:4). In addition, young people have a broad range of HIV/AIDS related needs hence services must be developed to respond to these needs.

2.3.5.1 Service delivery needs for young people

Studies conducted in Malawi revealed that young people require services that are provided by health care workers who are friendly and who are trusted to keep confidential any information about the young people (NYCOM 2000:34). Exit interviews conducted at an AIDS information centre in Uganda revealed that there were certain aspects of service that young people liked best when youth VCT was introduced at the centre. As many as 90,0% of these young people preferred friendly health care providers, 74,0% liked provider professionalism, 87,0% appreciated a warm reception on arrival while 30,0% liked confidentiality of results (Horizons Programme 2004:3).

Further studies in Kenya indicated that VCT sites were not equipped to respond to young people's issues. Service providers who were interviewed at some of the VCT sites indicated that, although they were providing testing services to young people, they had little preparation and experience in handling young people (Horizons Programme 2001:26). Therefore, it was recommended by Finger (2002:1) that as countries try to implement or expand VCT services for young people, programme planners need to establish policies and bolster support services, develop adequate training for counselors who work with young people, make existing services youth friendly and address potential problems of stigma and also recognise that care and support services are needed for those young people who test positive as well as those who test negative. In doing so, Boswell

and Baggaley (2002:7) suggested the following key features for youth friendly health services:

- Full participation of young people in decision making, planning and delivery of services
- Community mobilisation to increase understanding of young people's health needs
- Peer education through community outreach and clinic based educators and compensation packages to ensure participation and motivation
- Designated youth friendly corners
- Health service providers trained in youth friendly approaches to communication and counseling
- Suitable venues ensuring discretion for issues of consent and disclosure
- Integration with other post test health and psychological support services
- Confidentiality
- Adequate supplies of condoms; information, education and communication (IEC) materials as well as sufficient medicines.

A study conducted in Botswana further revealed that peer-led AIDS prevention intervention incorporating social-cognitive learning to enhance self efficacy is effective in changing HIV prevention related attitudes, knowledge and behaviours among ordinary African women (Norr, Norr, McElmurry, Tlou & Moeti 2004:223).

2.3.5.2 HIV/AIDS and VCT Information needs of young people

Young people would like to be provided with adequate information when they go for HIV testing. This is done through pre and post test counseling. Boswell and Baggaley (2002:7) indicated that it is clear that young people value opportunities for counseling and that more than one session is required to adequately explore their needs. It was further suggested that in supporting young people who have made a decision to be tested, adequate time should be available to provide information before and after the testing. This is called pre and post test counseling. According to Tabi and Frimpong (2003:248) counselling is done not only to focus on the avoidance of risk factors but also to facilitate individual risk assessment. Boswell and Baggaley (2002:7) suggested that the counselors may need to do the following during pre and post test counseling.

Pre test Counseling

- Explore their reasons for presenting for testing and providing unconditional support
- Affirm the young people's courage in seeking services and encourage their attempts to practise healthy behaviours
- Assess the young people's risks, perceptions and factors relating to vulnerability
- Outline the testing procedures and practices and find out what a positive or a negative result would mean to them and to whom they would disclose their status
- Provide health education and information as required

- Help young people to understand how they can reduce their risks of becoming HIV+ve
- Offer opportunities for young people to ask questions and discuss their concerns
- Distribute IEC materials as appropriate

Post Test counseling

- Explore each young person's readiness to receive results
- Revisit risk assessment and risk reduction planning
- Take an opportunity to practise behaviour modification, for example through a role play session
- Offer additional health education and information
- Allow them to ask questions and air their concerns
- Revisit the matter of their support systems, disclosure and coping capacities
- Refer them to appropriate services
- Plan for ongoing support as desired

2.3.5.3 *Models for provision of services to young people*

There are various models for young people to access VCT services and these include integration into primary health care as youth friendly venues or corners, integration into school and college health care services, youth centres and

mobile services (Boswell & Baggaley 2002:8). Each of these models has its own advantages and disadvantages. This requires involvement of young people to decide what is best for them taking into consideration concerns of the young people.

Young people are concerned with their privacy and are fearful that others may find out that they had an HIV test. Therefore, young people would want to have testing in facilities where they will not meet neighbours or parents and places where it is not easy for people to know that one had gone for testing. A study conducted in Kampala, Masaka and Nairobi by Horizons Programme (2001:27) reported various views of young people's choices of places to go for HIV testing among those who had already gone for testing and those who had never been tested. In Kampala 38,0% and 23,0% of tested young people preferred to get tested at a youth centre and VCT centre respectively compared to 41,0% untested young people who preferred hospitals and 41,0% who preferred youth centres (Horizons Programme 2001:27). On the other hand, in Masaka 67,0% and 12,0% of tested young people preferred to get a test from hospitals and schools respectively while 73,0% and 14,0% of untested young people preferred hospitals and youth centres respectively. In Nairobi 53,0% and 29,0% of tested young people preferred hospitals and clinics respectively while 73,0% and 16,0% of untested young people preferred hospitals and clinics respectively. This shows that there is no one ideal model for VCT for young people since different categories of young people in different settings had different preferences.

2.4 CONCLUSION

This chapter discussed the HBM and literature relevant to HIV and VCT in relation to the HBM constructs. The HBM formed the basis for the development of the interview guide that was used to collect the data. Previous research on the predictive utility of the HBM for HIV prevention behaviour, suggested that perceived susceptibility, benefits and barriers are the strongest predictors of HIV preventive behaviours (Peltzer 2000:39). These constructs were utilised in the research instrument and in the analysis and discussion of the research results.

Chapter three discusses the research methodology that was used in this research including the research design, setting, sampling, data collection and data analysis processes.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the research methodology which includes the research design, setting, population, sample, research instrument, data collection procedures and data analysis.

3.2 RESEARCH DESIGN

The research design is a blue print, or outline, for conducting the study in such a way that maximum control will be exercised over factors that could interfere with the validity of the research results (Polit & Hungler 1999:155). A good design will help the researcher to avoid bias while collecting the data. The purpose of the study was to explore and describe the factors that motivate young people to go for VCT in Malawi. This study therefore used a nonexperimental, descriptive and quantitative research design.

3.2.1 Exploratory descriptive design

This study was exploratory and descriptive because it explored factors that motivate young people to access VCT services in Malawi. Descriptive research aims at describing phenomena rather than explaining them and might be important in laying foundations for subsequent research (Polit & Hungler 1999:144). Descriptive studies do not focus on relationships among variables. Their purpose is to observe, describe and document aspects of a situation as it naturally occurs. The intent of this study was to document the aspects of the situation as they relate to young people's access to and utilisation of VCT services in Malawi.

Descriptive studies are considered to be an essential phase in the development of nursing knowledge because they form the basis for future research by generating questions and hypotheses for subsequent experimental studies (Streubert & Carpenter 1995:36). The focus of descriptive studies is on the situation as it is, that is, conditions that exist, practices that prevail, beliefs, attitudes and ongoing processes (Babbie 2001:93). The descriptive design was most appropriate for this study because it investigated factors that were not known. For more details on this topic to be collected, it required that there should

be a thorough description of the situations and events that are influencing the access to VCT services by young people in Malawi.

On the other hand, exploratory studies address issues that have not previously been studied and attempt to identify new knowledge, new sights, new understandings, and new meanings and to explore factors related to the topic. According to Polit and Hungler (1999:19) exploratory research aims at understanding the phenomenon of interest. This study met this criterion because it attempted to explore the full nature of young people's access to VCT services, related factors that motivate young people to access VCT services in Malawi as well as factors that hinder their access to these services. This design was deemed appropriate for this study since it led to a better understanding of reasons why young people in Malawi get motivated to go for VCT as an entry point for behavioural change as well as to access and utilise care and treatment for HIV, if they are HIV positive.

3.2.2 Non experimental research

A non experimental research design was used because it allowed the researcher to collect data without introducing any new treatments or changes to the subjects. Non experimental designs are conducted to explain phenomena and test the theoretical proposition to predict the occurrence and magnitude of the phenomena and to describe various characteristics and conditions (Polit &

Hungler 1999:178). There are multiple variables in the study, but the primary purpose was to describe the status of each and not to relate them to one another.

By using nonexperimental research, it ensured that social processes occurring in natural social settings were observed which might not be the case with experimental research (Babbie 2001:235). In addition, the non experimental design was used because the study was descriptive. Since the intent of descriptive research is neither to explain nor to understand the underlying causes of variables of interest, experimental designs were not deemed appropriate for this particular study (Polit & Hungler 1999:175).

A nonexperimental design was furthermore appropriate because, according to Polit and Hungler (1999:177), a vast number of characteristics associated with individuals are inherent and not subject to experimental control. The variables of interest in this study concern human perceptions and behaviours which would be difficult to collect using experimental research. It is therefore a nonexperimental design that would facilitate the collection of the required information in the natural settings of the respondents.

3.2.3 Quantitative approach

The approach used in this study involved the systematic collection of quantifiable information. The data entry and analyses were done using the Epi info version 6.0 and Statistical Package for Social Scientists (SPSS) version 11 computer program to derive statistics. This approach was chosen because the study aimed at quantifying factors identified as motivating young people to go for VCT in Malawi.

3.2.3.1 *Characteristics of quantitative research*

This study complied with the characteristics of quantitative research as stipulated by Polit and Hungler (1999:24) including that:

- Quantitative research focuses on a relatively small number of specific concepts which in this case are VCT and young people in Malawi.
- Quantitative research begins with preconceived ideas about how the concepts are interrelated. In this study, there was an indication that young people might not be going for VCT which means that there is an interrelationship between young people and their access to VCT.

- Quantitative research uses structured procedures and formal instruments. A structured interview schedule was used to collect data in this study from young people.
- Quantitative methods emphasise objectivity in the collection and analysis of the data. Objectivity was achieved in this study through the use of a structured interview schedule and approved statistical methods and procedures for data analysis.

3.3 RESEARCH SETTING

The research setting refers to the place(s) where the data are collected. The study was conducted in catchment areas of three facilities offering VCT services and these were Chitipa District Hospital, Kamphata Youth Centre and Bangwe Health Centre. Chitipa District is a rural district situated in the northern region of Malawi, Kamphata Youth Centre is situated in the central region of Malawi in Lilongwe District, (Lilongwe is the Capital City of Malawi) and is a stand alone site that provides VCT services, while Bangwe Health Centre is situated in the peri-urban area of Blantyre city which is in the southern region of Malawi (see Annexure A: map of Malawi).

3.4 RESEARCH POPULATION AND SAMPLE

A population is defined by Polit and Hungler (1999:43) as the totality of all subjects that conform to a set of specifications, comprising the entire group of persons that is of interest to the researcher and to whom the research results can be generalised. A sample is a subset of a population selected to participate in a research study (Polit & Hungler 1999:654).

3.4.1 Population

The research population in this study were therefore all the young people aged 14-25 years in the catchment areas of Chitipa District Hospital, Kamphata youth centre and Bangwe health centre. Malawi's Ministry of Health has indicated that a catchment area of a health facility covers an 8-10 kilometer radius of the facility (MoHP 1999:16). Chitipa District Hospital has a catchment population of 37 303; Kamphata youth centre has a catchment population of 60 610, while Bangwe health centre has a catchment population of 145 775. According to the population census of 1998 in Malawi, young people aged 14-25 comprise 33,0% of the population (NYCOM 2000:7). Therefore it is estimated that there were 20 000 young people in Kamphata, 43 732 in Bangwe and 12 309 in Chitipa catchment areas.

The population considered in this study were all young people aged 14-25 who had gone for VCT in the three identified areas, as the study focussed on young people who had utilised VCT services in these areas in Malawi. The accessible

population is the population of subjects available for a particular study, often a non random subset of the target population (Polit & Hungler 1999:639). It is the aggregate of cases that conform to the designated criteria and are accessible to the researcher as a pool of subjects for the study. The eligibility criteria in the study included those young people aged 14-25, male and female, who lived in the catchment areas of Chitipa district hospital, Kamphata youth centre and Bangwe health centre, who had gone for VCT and were willing to participate in the study. Eligibility criteria are the specifications used by the researcher that designate the specific attributes of the target population determining which subjects are selected for participation in a study (Polit & Hungler 1999:644). The inclusive criteria were therefore those young people who met the eligibility criteria, who attended a specific clinic on the day(s) that the researcher was there to conduct interviews, and those young people who had gone for testing before the study.

3.4.2 Sample and sampling procedure

The sampling approach which was used in this study is that of non-probability or convenience sampling, because it entailed the participation of the most conveniently available persons or subjects in this study (Polit & Hungler 1999:257). This approach was chosen because there was no information available of all the young people residing in the areas where data were collected which would have formed a sampling frame, or census. A sampling frame is the

listing of the sampling units or elements from which the sample will be chosen (Polit & Hungler 1999:654), in the case of a random sample. As no sampling frame existed about young people in these study sites in Malawi, random sampling procedures could not be adopted for this study.

3.4.2.1 *Characteristics of non -probability sampling*

Polit and Hungler (1999:260) as well as Burns and Grove (1999:238) have indicated that non-probability sampling designs are practical and economical. In addition, every person who meets the criteria is asked to participate and the researcher's judgement is not used to select individual participants.

Non-probability sampling has a disadvantage which stems from the fact that not every element in the population has an equal chance of being included in the sample. Therefore, it is possible that some segment of the population might be systematically over or under represented (Polit & Hungler 1999:260). This implies that the research results might not be generalisable beyond the sample.

3.4.2.2 *Sample*

The sample in this study was planned to be 150 but 145 participants were interviewed due to some limitations. The number of participants was reached

based on the number of young people tested. According to NSO (2005:26) on average, five percent of young people have gone for testing hence in each site five percent of the population of the young people was calculated. The eligible population in the three study sites was therefore 3,802. The sample was identified by targeting four percent of the eligible population hence the sample of 150. The researcher would have wished to interview at least 25,0% of the eligible participants to have a representative sample size, but due to financial and time limitations it was not possible.

3.4.3 Recruitment of participants in the main study

Participants for the study were recruited using convenience sampling. The researcher identified the participants in the catchment areas of the three VCT sites by moving around the villages to identify the young people who were eligible to participate in the study. Before identification of the participants, the researcher, in collaboration with the VCT facility providers visited the traditional authorities in the area to obtain permission to conduct the study in the specific area. A deliberate effort was made to interview young people of all age groups (14-25) and both sexes to ensure that all categories of young people were represented.

To recruit those who got tested prior to commencement of the data collection process, snowball sampling was used. This method was used because the

research population consisted of individuals with specific traits which were difficult to identify by ordinary means (Polit & Hungler 1999:256). This was the case because no register existed of all young people who had used the VCT services, as this information was treated confidentially. Therefore, young people who had been tested and were identified during the study were requested to refer their peers, who had used VCT services to the researcher for interviews, should they be willing to be interviewed. In this way no names were disclosed to the researcher and the decision whether or not to participate in this study remained the sole prerogative of every person who had used VCT services in the study sites' catchment areas. The existing networks of young people such as post test clubs (PTC) were also used as a channel for identifying young people who had been tested. In addition, those who were tested during the researcher's visits to the specific sites, and who were willing to participate in the study, were interviewed, at these sites.

3.5 DATA COLLECTION

Data refer to information obtained during the course of an investigation or study (Polit & Hungler 1999:267). A structured interview schedule was used to collect the data. The development of a formal instrument ensured that similar data were collected from all the participants and this also ensured that objectivity was maintained throughout the data collection process.

According to Babbie (2001:268), the use of structured instruments can lead to obtaining information that is relatively superficial since interviewers rarely probe deeply into such complexities as contradictions of human behaviour and feelings. Some open ended questions were included in order to obtain some responses in the participants' own words, attempting to address some shortcomings in the use of closed ended items in the structured interview schedule. Conducting interviews is demanding in terms of personal time and other resources.

3.5.1 Data collection instrument

The data were collected through conducting personal interviews using structured interview schedules. This method was chosen because according to Polit and Hungler (1999:298), it is the most powerful method of securing information since the interviewer will meet each individual participant face to face and obtain information from him/her. Individual interviews were conducted with all identified respondents. This option was preferred to other techniques because there was an opportunity to clarify some areas that were not clear. Both open and closed ended questions were used in the structured interview schedule. Open ended questions are questions that do not restrict the respondents' answers to pre-established alternatives. Closed ended questions offer respondents a set of mutually exclusive and jointly exhaustive alternative replies, from which the one most applicable answer must be chosen (Polit & Hungler 1999:282). Closed

ended questions are used when there are a fixed number of alternative responses presented to the participants.

3.5.1.1 *Advantages and disadvantages of face to face interviews*

According to Babbie (2001:258), face to face interviews have the following advantages:

- The response rate tends to be high since the subjects are apparently more reluctant to refuse to talk to an interviewer who is directly in front of them.
- Interviews offer some protection against ambiguity of confusing questions since the interviewer can ask probing questions to clarify any ambiguous answers.
- The interviewer has strict control over the ordering of the presentation of the questions and has greater control over the sample in the sense that the interviewer knows whether or not the person being interviewed is the intended respondent.

On the other hand, face to face interviews have some disadvantages which include the fact that the presence of the interviewer may affect the respondent's perception of a question or answer given (Babbie 2001:259). Conducting face to face interviews is time consuming and demands that the interviewer travels to all the sites participating in the study.

3.5.1.2 *Structure of the interview schedule*

The interview schedule consisted of the following sections (see Annexure F)

- Section A Classification data
- Section B Biographic data
- Section C VCT knowledge and decision making
- Section D VCT services

3.5.2 Reliability of the research instrument

An ideal instrument results in measuring relevant, accurate, unbiased, sensitive, uni-dimensional and efficient data. This is done through validity and reliability testing of the instrument. Reliability of an instrument is the degree of consistency with which it measures the attribute it is supposed to be measuring and whether a particular technique, applied repeatedly to the same object, yields the same result each time (Babbie 2001:140). An instrument can be said to be reliable if its measures accurately reflect the true scores of the attribute(s) under investigation. Reliability is a measure used to assess the quality of the instrument as it measures the instrument's degree of consistency (Polit & Hungler 1999:653).

Reliability of a measuring tool can be assessed in several ways depending on the aspect of the reliability concept that is of greatest interest. There are different ways in which reliability of an instrument can be measured and these include stability, internal consistency and equivalence.

3.5.2.1 *Stability of an instrument*

Stability of an instrument refers to the extent to which the same results are obtained on repeated administrations of the same instrument (Polit & Hungler 1999:368). This is when a researcher administers the same test to a sample of individuals on two occasions and then compares the scores obtained. This is called test-retest reliability. This method was applied in this study by pre-testing the interview schedule in three sites and the results of the pre-tests were compared. Areas that needed revision after the pre-test were revised.

3.5.2.2 *Equivalence*

This technique is used when different observers or researchers are using an instrument to measure the same phenomena at the same time or when two presumable parallel instruments are administered to individuals at about the same time (Polit & Hungler 1999:372). The aim is to determine the consistency or equivalence of instrument in yielding measurements of the same traits in the

same subjects. This technique was not applicable to this study because there was only one interviewer involved.

3.5.2.3 *Internal consistency*

This is when all subparts of an instrument measure the same characteristics (Polit & Hungler 1999:371). This is done using what is called split half technique. According to Babbie (2001:142) it is always good to make more than one measurement of any subtle or complex social concept. This is when items in a research instrument are randomly assigned to two sets and each set should provide a good measure of the phenomena of interest and should classify respondents the same way.

To get to this stage, the interview guide was pre-tested before administration to ensure that the instrument measured what it was intended to measure. The first most efficient way to find out how good an interview schedule is to pre-test it with a group of respondents who have the same characteristics as those involved in the study. It should be noted that those who participated in the pre-test were excluded from participating in the actual research project. The pre-testing was done at different sites from where the actual research was conducted. The findings of the pre-test required the researcher to make amendment to some questions.

3.5.2.4 *Pre-testing of the instrument*

The draft interview guide was discussed with statisticians who were knowledgeable about the construction of structured interview schedules and people familiar with substantive content of the structured interview schedule, namely VCT. This was done to ensure that all the important steps and details had been taken care of before pre-testing. The final draft was then pre-tested among young people meeting the set eligibility criteria at three VCT sites in Lilongwe and Blantyre districts. These sites were excluded from participating in the actual study. Consequently all persons who participated in the pre-test did not participate in the actual study. The participants did not participate in the main study because the concern of involving participants who have participated in pre-testing is that they have already been exposed to an intervention and, therefore, may respond differently from those who have not previously experienced it. Pre-testing is the trial run to determine, as far as possible, the clarity, research adequacy and freedom of bias. The pre-test was done with individuals who had similar characteristics to those who were interviewed in the study (Polit & Hungler 1999:289).

Areas needing revisions were revised after the pre-test and then the instrument was finalised. As a result of the pre-testing, Item 14 on the structured interview schedule's closed ended answers had to include "MACRO", as this voluntary organisation's stand-alone VCT sites had been used by a number of participants

in the pre-test. The participants' answers to some questions were so similar that the initial questions 24, 27 and 30 were merged to produce question 24 only. In a similar way the initial questions 31 and 32 were merged and became question 29 on the revised structured interview schedule.

3.5.3 Validity of the research instrument

Validity refers to the degree to which an instrument measures what it is supposed to be measuring. It is the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration (Babbie 2001:142). There are three methods of validating a research instrument, namely criterion-related validity, construct validity and content validity.

3.5.3.1 *Criterion-related validity*

In this method, which is sometimes called predictive validity, emphasis is on establishing the relationship between the instrument and some other criterion (Polit & Hungler 1999:376). An essential component is the availability of a reasonably reliable and valid criterion with which the measures obtained from the target instrument can be compared. It might be difficult in this study to predict such criteria with which to compare the instrument.

3.5.3.2 *Construct validity*

This is based on the logical relationship among variables (Babbie 2001:142). Construct validity is used by researchers concerned with questions like what is this measuring device really measuring and more concerned with the underlying attribute than with the scores that the instrument produces. The significance of construct validity is its linkage with theory and theoretical conceptualisation and there is an emphasis on logical analysis and the testing of relationships predicted on the basis of theoretical considerations (Polit & Hungler 1999:377).

One common approach to this technique is called known-groups technique where groups are expected to differ on the critical attribute because some known characteristics are administered in the instrument (Polit & Hungler 1999:377). This is applicable in this study since there are known characteristics like gender and age. There might be differences on reasons for going for VCT between the younger age group who may not be sexually active to the same extent as the older ones. In addition, there are expected to be differences between VCT experiences by males compared to females.

3.5.3.3 *Content validity*

This refers to how much a measure covers the range of meanings included within a concept (Babbie 2001:144). The issue of concern under content validity is

whether the items of the research instrument are representative of the content domain that the researcher intends to investigate (Wood & Haber 1998:331). These authors suggest that in order to ensure content validity of the instrument, the instrument should be submitted to a panel of judges considered to be experts in the field of study.

The interview schedule in this study was submitted to a panel of experts whose work involves adolescent health and VCT. These experts included youth workers at Malawi's Ministry of Youth, VCT coordinators in the Ministry of Health and with the National AIDS Commission and National Statistical Office. These consulted persons are experts in research and in VCT. The experts were asked to comment about the relevance of each question in the structured interview schedule. The feedback from them was used to make alterations to the interview schedule

3.5.3.4 *External validity*

External validity refers to the generalisability of the research findings to other settings or samples (Polit & Hungler 1999:239). One aspect of a study's external validity concerns the adequacy of the sampling design. External validity was ensured in this study by having young people from different regions of the country participate, both males and females and from the age groups of 14-25.

3.6 ETHICAL CONSIDERATIONS

The protection of the rights of human subjects has become high priority among members of scientific and health care communities (Polit & Hungler 1999:29). In this research, ethical issues were taken into consideration especially realising that VCT is a sensitive issue and that HIV is a human rights issue. To ensure that ethical issues are taken into consideration, various steps were followed:

- A letter to Malawi's Ministry of Health's Research and Ethics Committee was written with an attachment of the research proposal to request the Ministry to authorise the researcher to carry out the research (see Annexure C). This was done to ensure that the study met the ethical standards of the MoH. Authorisation was given by this ministerial committee for the study to be conducted (see Annexure D). The committee initially suggested that the research should include young persons who had not utilised VCT services. After discussions between the committee members and the researcher it was agreed that the study should focus on those who had indeed utilised the VCT services.
- The protection of the rights of the participants was a priority in this study. The respondents were clearly informed about the purpose of the study and that their responses would remain totally anonymous (see Annexure E). In addition, respondents were asked to voluntarily participate or to discontinue doing so at any point should they wish to without incurring any

ill effects whatsoever. This ensured that their rights to self determination and full disclosure remained protected. The right to self determination means that prospective participants have the right to voluntarily decide whether or not to participate in a study without the risk of incurring any penalties or prejudicial treatment (Polit & Hungler 1999:33). On the other hand, the right to full disclosure means that the researcher has fully described the nature of the study, the subject's right to refuse participation, the researcher's responsibilities and the likely risks and benefits that would be incurred. Should any participant withdraw at any stage, he/she will not incur any negative consequences whatsoever. As only structured interviews were conducted, the participants were never subjected to any harmful effects. However, talking about VCT might be traumatic to young persons who learned that they were HIV+ve as a result of using these VCT services.

- The right to privacy was also respected in this research to ensure that it is not intrusive into the participants' personal lives. As such the data collected was kept anonymous and confidential by adhering to the following steps as suggested by Polit and Hungler (1999:36). No identifying information was collected from the participants. In addition, the information obtained was accessible to the researcher only. The respondents were also assured of confidentiality and guaranteeing them that any information they provided would not be publicly reported or made accessible to parties other than those concerned with the research. The

researcher kept all data locked up. Once the research report has been accepted, the researcher will destroy all documents containing raw data. The research report only portrays figures and statistics and discussions but no names. No person and no institution has been identified in this report.

- The participants were asked to sign an informed consent form (Annexure B) based on the rights to self determination and full disclosure. The signed consent form was sealed in an envelope and placed into a sealed container. The anonymous completed interview schedule was placed into another sealed container so that neither the interviewer nor any other person could link the signed consent form with any completed interview schedule. This was done after the participants were informed about the purpose of the study, how they were selected, potential benefits, confidentiality pledge, right to withdraw and that participation was voluntary (Polit & Hungler 1999:36-37).
- To ensure scientific honesty on the part of the researcher, no plagiarism has been committed and any source of information has been acknowledged. In addition, objectivity was applied during data collection, analysis and discussion.

3.7 METHODS OF DATA ANALYSIS

Data analysis is the systematic organisation and synthesis of research data, a testing of the research hypothesis using the data (Polit & Hungler 1999:643). The data in this research were entered using the EPI Info version 6 computer program and analysed using Chi-square statistics by using the Statistical Package for Social Sciences (SPSS) version 11 program. According to Polit and Hungler (1999:541), SPSS version 11 is a computer package which has programmes that handle a broad variety of statistical analyses. Chi-square statistics are used when there are categories of data and hypotheses concerning the proportions of cases that fall into various categories. Chi-square statistics are applied to contingency tables, testing the significance of different proportions.

3.8 CONCLUSION

This chapter discussed the research methodology that has been used in this research which includes research design, setting, sampling, data collection and data analysis. Chapter 4 presents the data analysis and discussions of the research results.

CHAPTER 4

ANALYSIS AND DISCUSSION OF RESEARCH RESULTS

4.1 INTRODUCTION

This chapter presents and discusses the results of the study. The purpose of the study was to explore and describe factors that motivate young people aged 14 – 25 to access VCT services in Malawi. Furthermore, factors hindering access to VCT services in Malawi would also be identified and described. This information will be used to recommend ways in which VCT services in Malawi could become more accessible to more young people aged 14-25. The objectives of the study were to:

- determine reasons why young people go for VCT in Malawi
- identify possible barriers experienced by young people in accessing VCT services in Malawi
- identify strategies that could promote young people's access to VCT services in Malawi

The researcher planned to have 150 participants (as explained in chapter 3 of this dissertation) but 145 participants eventually took part in the study due to non availability of participants and time as well as financial limitations. The data

obtained from the 145 interview schedules were analysed and will be discussed in this chapter.

The section that follows will present demographic data. This will be followed by results on the decision making by young people regarding access to VCT. The fourth section will present and discuss findings on VCT services. All figures will be rounded off to the nearest decimal point.

4.2 DEMOGRAPHIC DATA

This section will address the research results pertaining to participants' gender, age, education levels, residential areas, persons with whom the participants live, marital status, sexual experiences and youth club membership.

4.2.1 Gender

There were more male 55,2% (n=80) than female 44,8% (n=65) participants who had undergone HIV testing before and during the time of the survey (see Figure 4.1). This result mirrors the Malawi Demographic and Health Survey preliminary results for 2004 which showed that more males (7,0%) had undergone HIV testing than females (4,0%) hence the difference in number is justified (NSO 2005:26). However, the difference in number of males and females who

participated in the study does not have a great impact on the results which remain comparable because the sample represents both genders.

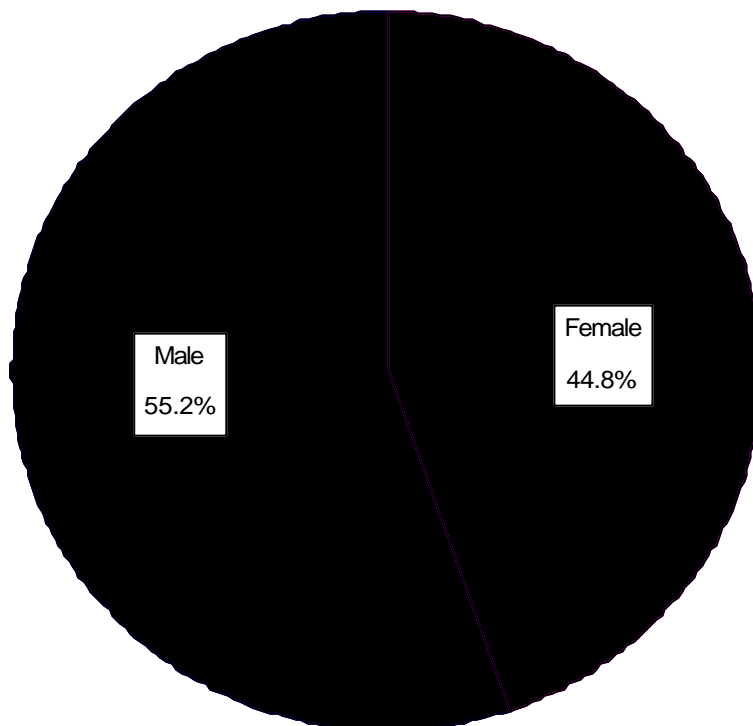


Figure 4.1: Gender distribution of participants

The gender distribution of the participants had been anticipated to be an important demographic factor influencing the findings because gender affects the sexual behaviour and decision making powers of the young people in Malawi. In

most cultures in Malawi, women are not expected to be initiators but merely receivers of decisions made by men with regard to many issues, including sexual aspects. Females are brought up in such a way that they have to be submissive and are least likely to have decision-making power regarding their own health care (Kinoshita 2003:1). This would lead to having different factors motivating young females as compared to young males to access VCT services.

4.2.2 Age

The ages of the participants ranged from 14 to 25 years. Twenty percent (n=29) of the participants were aged between 14 and 17 years, 44,0% (n=64) were aged between 18 years and 21 years while 36,0% (n=52) were aged between 22–25 years (see Figure 4.2). The mean age of the participants was 20,25 years (male=20,5; female=19,9). Those young people aged up to 17 years were few but this was expected because few young people within this age group have gone for HIV testing in Malawi. This is the case because the minimum age for consent for HIV testing is 16 years according to Malawi's national guidelines for VCT (MoH 2004a:12). However, these guidelines allow young people who are sexually active, pregnant or married to give consent for VCT at the age of 13 since they are considered to be mature minors under these circumstances. This explains why there were some respondents who were younger than 16 years of age in the sample.

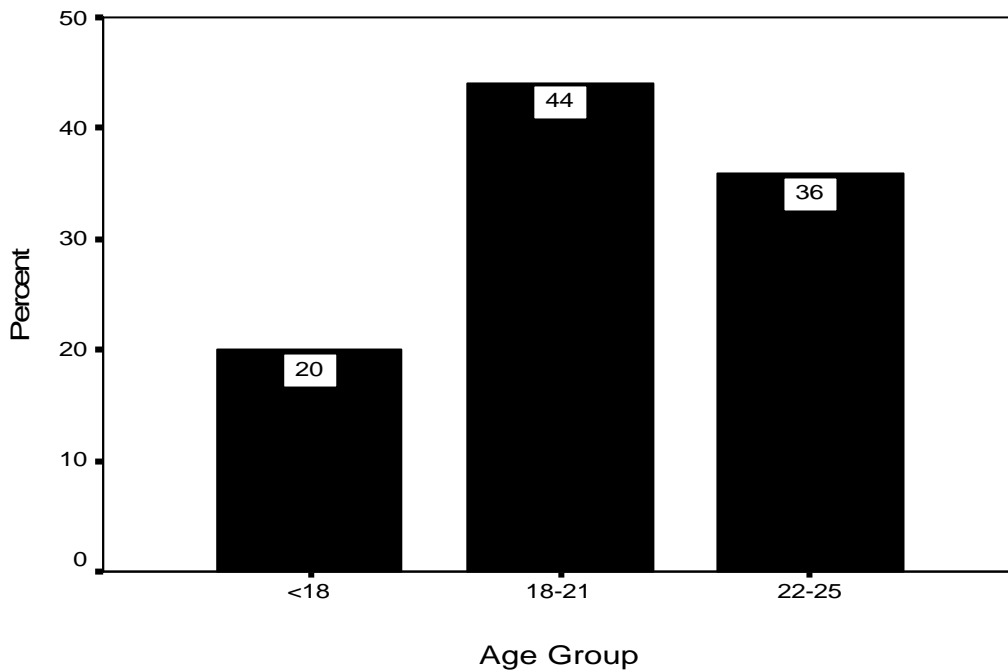


Figure 4.2: Age distribution of VCT acceptors

4.2.3 Educational levels

All participants had attended school to a certain level. Fifty four percent of the participants (n=78) were still in school while 46,0% (n=67) were not in school. The education levels of the participants varied as indicated in Table 4.1.

Of those who were not in school during the time of the study (n=67), 22,4% (n=15) last attended school less than a year ago, 41,8% (n=29) last went to

school between one and three years ago while 35,8% (n=24) stopped attending school more than five years ago. The figures show that as many as 64,2% (n=43) of the young people had left school within three years before the survey. This may imply that HIV and VCT knowledge gained during the school going period may still be influencing these young people's access to VCT services.

Table 4.1: Level of education attained

Education level	Frequency	Percent	Cumulative Percent
Primary	13	9,0	9,0
Junior secondary	34	23,4	32,4
Senior secondary	82	56,6	89,0
Tertiary	16	11,0	100,0
Total	145	100,0	

Education status had been anticipated to be a factor influencing access to VCT and this was confirmed by the results of the study as shown in Figure 4.3. All young people who were interviewed (and had gone for VCT) were either in school or had attended school to a certain level. More than half of the participants (56,6%;n=82) had secondary school qualifications while few had primary (9,0%;n=13) and junior secondary (23,4%;n=32) school qualifications.

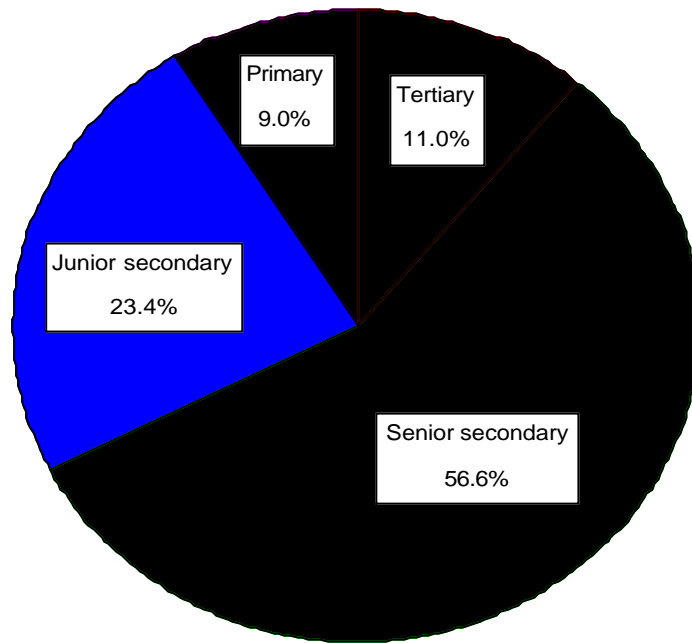


Figure 4.3: Distribution of VCT participants by level of education attained

These results support the findings of studies conducted in several countries which revealed that 69,0% of young people who had secondary and higher education, knew where to get tested compared to 38,0% and 20,0% of those who had primary education and no education respectively (UNICEF, UNAIDS & WHO 2002:32). This might imply that educational levels influenced young people's decisions about and access to VCT services. Consequently, more young people

who have never gone to school are missing an opportunity of accessing VCT information through the school.

4.2.4 Residential areas of participants

The findings indicated that 30,3% (n=44) of the participants were residing in rural areas, 31,0% (n=45) in semi-urban areas while 38,6% (n=56) resided in urban areas (see Figure 4.4).

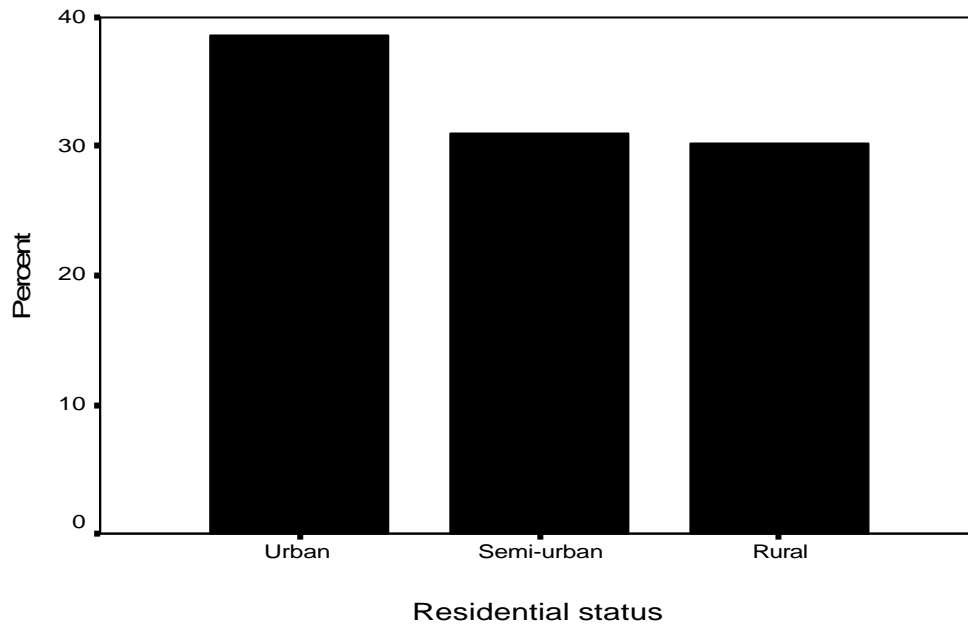


Figure 4.4: VCT participants' residential areas

There was a significant difference between genders of participants in relation to residential status. This is revealed by Pearson's Chi-square analysis which yields an asymptotic significance value of 0,03, which is obviously less than the confidence level of 0,05 (2-tailed test; 2 df). In fact cross-tabulation of the data shows that more females (72,3%; n=47) in the semi-urban and rural areas were willing to participate in the study whereas more males (47,5%; n=38) in the urban

areas used VCT services. This might be the case because in the urban areas HIV rates are higher (20,4%) among females compared to those in the rural (13,0%) and semi-urban areas (17,0%), as revealed by the sentinel surveillance report of 2004 (NAC 2005:11).

4.2.5 Persons with whom participants lived

Almost two thirds (62,0%, n=90) of the participants stayed with their parents, 22,8% (n=33) stayed with their relatives, 13,1% (n=19) stayed alone while 2,1% (n=3) stayed with friends. (See Figure 4.5 for details).

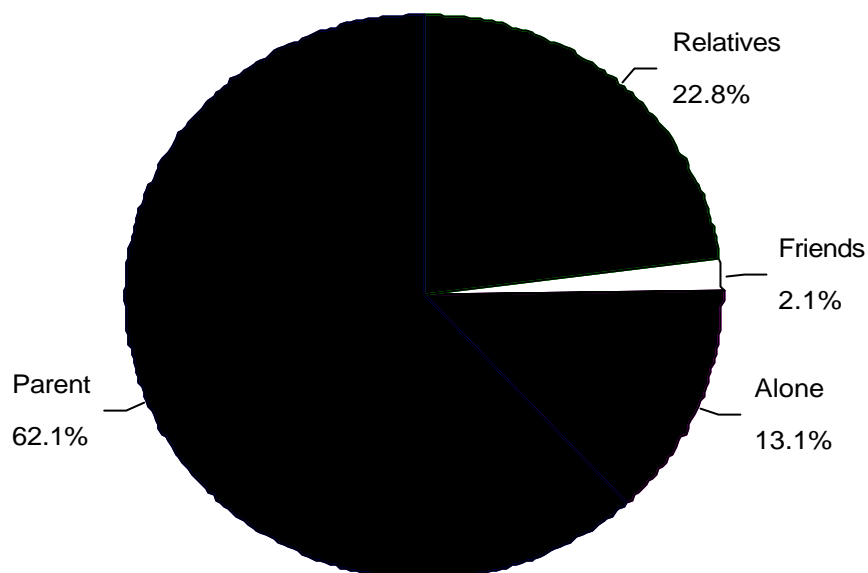


Figure 4.5: Persons with whom participants lived

Many participants stayed with their parents and a good number stayed with their relatives. The results show that the majority of the participants were either in school or had last gone to school in the last three years (see section 4.2.3). In Malawi school-going young people remain their parents' responsibility hence the scholars mainly stayed with parents. Staying with parents could facilitate or hinder young peoples' access to VCT services. Parents are expected to provide

sexuality information and guidance to their children. However, many parents do not fulfil this role in Malawi where it is taboo for parents to discuss sexual issues with their children (Maluwa & Kawala 2003:46). This is evident in this study since there was no big difference in the number of young people who went for VCT and stayed with their parents or with other people.

4.2.6 Marital status

The majority of the participants (84,1%, n=122) were single as shown in Table 4.2.

Table 4.2: Marital status of the participants

Marital status	Frequency	Percent
Single	122	84,1
Married	20	13,8
Widowed	3	2,1
Total	145	100,0

These findings had been expected as most respondents were still in school as indicated in section 4.2.3 of this dissertation. In addition, marital status could be an influencing factor for young people's access to VCT due to repeated exposure to un-protected sex among married people which would make young people to

feel at risk of having HIV. This is mostly the case with young females because married women in Malawi encounter difficulties in negotiating condom use given their low status compared to men (Kinoshita 2003:70).

4.2.7 Single participants' sexual experiences

Of those participants who were single, 60,7% (n=74) reportedly had sexual intercourse experiences while 39,3% (n=48) reportedly never had sex. Out of the 74 respondents who had sex, 32,0% (n=24) reportedly had only single sexual encounters while 68,0% (n=50) had sex more than once (see Table 4.3).

Table 4.3: Sexual experience by gender and age group of participants

Age Group	Ever had sex		Total
	Yes	No	
Up to 17	12 (16,2%)	16 (33,3%)	28 (23,0%)
18-21	34 (45,9%)	23 (47,9%)	57 (46,7%)
22-25	28 (37,8%)	9 (18,8%)	37 (30,3%)
Total	74 (100,0%)	48 (100,0%)	122 (100,0%)

As expected, exposure to sex was more frequent among the young people aged 18 years and above (83,7%; n=62) whereas fewer of those aged up to 17 years had been exposed to frequent sexual encounters. This is confirmed by Pearson's Chi-square analysis that revealed that there is a significant difference between

the age groups with respect to their exposure to sex ($\alpha < 0,05$, 2 df). This is an encouraging result because it indicates that the younger people who were not exposed to sexual activity still sought VCT.

4.2.8 Youth club membership

Slightly more participants (55,2%, n=80) belonged to a youth club while only 44,8% did not belong to any youth club.

Young people participating in youth club activities are expected to be more knowledgeable since they have more time and opportunities to discuss sexual and HIV related issues. One can therefore conclude that belonging to a youth club is one of the factors that motivate young people to go for VCT since they have more ready access to information on VCT on a regular basis, as most youth clubs in Malawi do supply HIV and VCT information to their members. These findings might have been influenced by the fact that members of the post test club (PTC) were invited to participate in this research, and a number of these members actually participated.

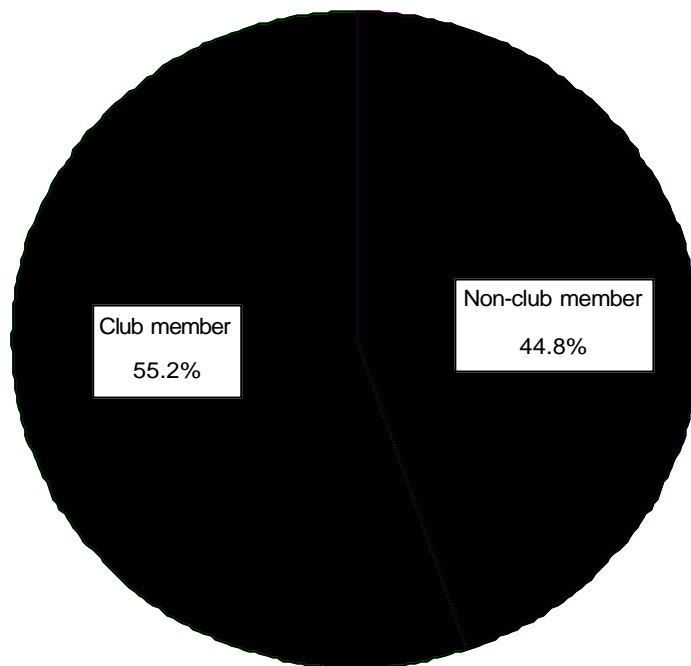


Figure 4.6: Membership of youth clubs

4.3 VCT KNOWLEDGE AND DECISION MAKING

Information young people had with regard to VCT and the decision to go for HIV testing is one of the important areas of the study. In the following sections the sources of information, motivation for decision to go for VCT, places where they sought testing services and reasons for testing are discussed.

4.3.1 First source of VCT information

The most common prime sources of information on VCT were friends, the radio and schools. Figure 4.7 presents details of the first participants' sources of information.

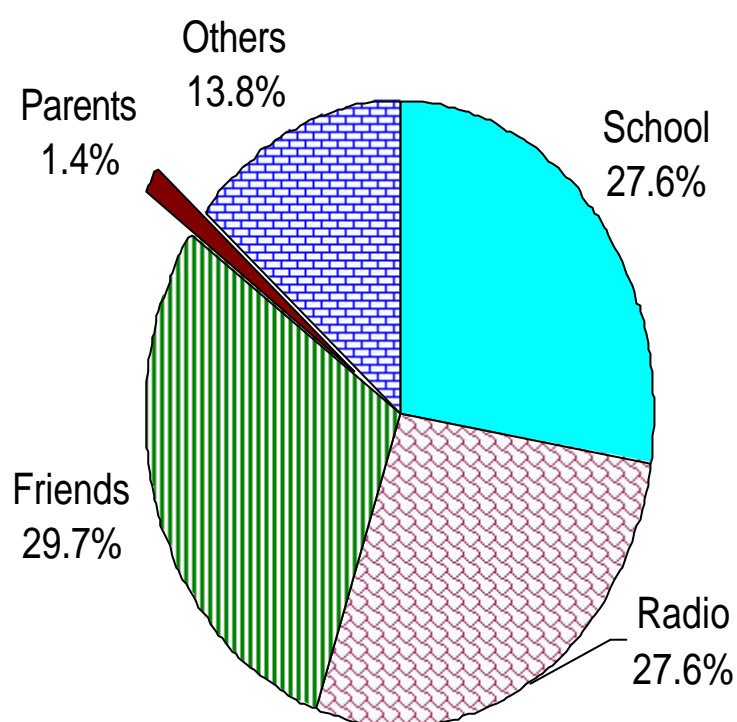


Figure 4.7: Primary source information on VCT

These results support the findings of another study conducted in Malawi among young people which revealed that their three main sources of information were

radio (39,5%), youth clubs (34,6%) and 11,0% schools (Maluwa & Kawala 2003:43). Friends are seen as playing a very important role in influencing their peers to access VCT services. It is therefore important to see to it that young people are empowered to provide accurate information to their peers to enable more young people to go for VCT.

The school is reportedly also an important source that needs to be strengthened. This contradicts the findings of a study conducted in Malawi on young people by Geloo (1999:102) which indicated that only 16,0% of the participants considered teachers as a source of information of sexual information. The difference might exist because during the time that Geloo conducted that study, there was a lack of sex education programmes in schools in Malawi. On the other hand, during the time of this study, sex education had been incorporated into the school curriculum as part of life skills education. This has led to teachers being compelled to teach about HIV/AIDS and VCT. Hence more school-going young people should get VCT information from schools in Malawi than before and during 1999 when Geloo's study was done.

The radio was also mentioned as an important source of information for VCT (27,6%; n=40). Many VCT-related radio programmes, targeting young people in Malawi, broadcasted prior to and during the data collection phase of this study. These broadcasts explained why so many respondents reportedly obtained their VCT information from the radio. These programmes are produced and presented

by their peers in a manner that is interactive through phone-in programmes and writing letters. This could be the reason why more young people are listening to such programmes since they are produced in a youth friendly manner. This is also where there is the link with friends as a source of information since as much as the information is from the radio, peers are the ones that are providing most of the information. It is therefore important to make radios available and accessible to young people to enhance their access to information.

Another finding noted in this study was that parents ranked very low (1,4%; n=2) as a source of VCT information for their children and yet the majority of the participants stayed with their parents, as discussed in section 4.2.5 of this chapter. This finding supports the findings by Munthali et al (2004:23) who reported that only 5,0% of the young people who participated in their study mentioned parents as their source of sexual information. This is attributed to the Malawian culture where parents are not seen as the primary source of sexual information for their children because 75,7% and 63,2% parents are not comfortable to talk about condoms and SRH issues respectively with their children (Maluwa & Kawala 2003:47). Even greater difficulties in talking about sexuality issues occur between parents and children of the opposite sex.

Children spend most of their time with parents at home and it is expected that parents provide guidance to their children as they grow up. It is being recommended that with the high HIV rates in Malawi among young people,

parents need to play a bigger role in providing sexual information to their children (NAC 2005:19). This implies a need to develop communication interventions targeting parents to improve their dialogue with their children about sexuality, including HIV/AIDS and VCT.

4.3.2 Decisions to go for testing

The majority of the participants (77,9%; n=113) took their own decisions to go for VCT while only 22,1% (n=32) were influenced by others to go for testing. With respect to age, the tabulation of data (see Table 4.4) shows that more young people in the older age group of 18-21 and 22-25 years tended to take personal decisions while the younger people (37,9%; n=11) aged up to 17 years had to be told by relatives to go for VCT.

Table 4.4 Decision making for going for VCT by age group

Decision for VCT	Age Group						Total
	Up to 17		18-21		22-25		
	n	%	n	%	n	%	
Self	18	62,1%	58	90,6%	37	71,2%	113
Someone else	11	37,9%	6	9,4%	15	28,9%	32
Total	29	100,0%	64	100,0%	52	100,0%	145

The findings indicate that the age of respondents differed significantly with deciding to go for VCT alone or after someone else influenced their going for testing. Statistical tests based on Pearson's chi-square and the Likelihood Ratio show highly significant difference ($\alpha = 0,003$) between age of respondent and deciding to go for VCT as shown in Table 4.5.

Table 4.5: Chi-Square tests of the relationship between age group and decision maker

	Value	df	Asymptotic Sig. (2-sided)
Pearson Chi-Square	11,628	2	,003
Likelihood Ratio	12,256	2	,002
N of Valid Cases	145		

The findings show that young people are empowered to take their own decisions to go for VCT. This might be the case because of the life skills education programmes that are provided to in- and out-of-school young people in which one of the issues discussed is decision making. It is therefore important to ensure that young people are empowered to make decisions to go for VCT. On the other hand, going for VCT is still a sensitive issue in Malawi where most people do not want anyone to know that they had used VCT services. This is more common among young people who indicated that they do not want to go for testing because they would then be considered to be sexually active by people

who knew that they had utilised the VCT services and would live a stressful life if found to be HIV+ve (Munthali et al 2004:27). This fear might influence young people to make independent decisions to go for VCT to ensure that they maintain their confidentiality and avoid the possible stigma associated with having utilised VCT services.

4.3.3 Places where young people utilised VCT services

Some of the participants (44,1%; n=64) got tested at a youth centre (figure 4.8).

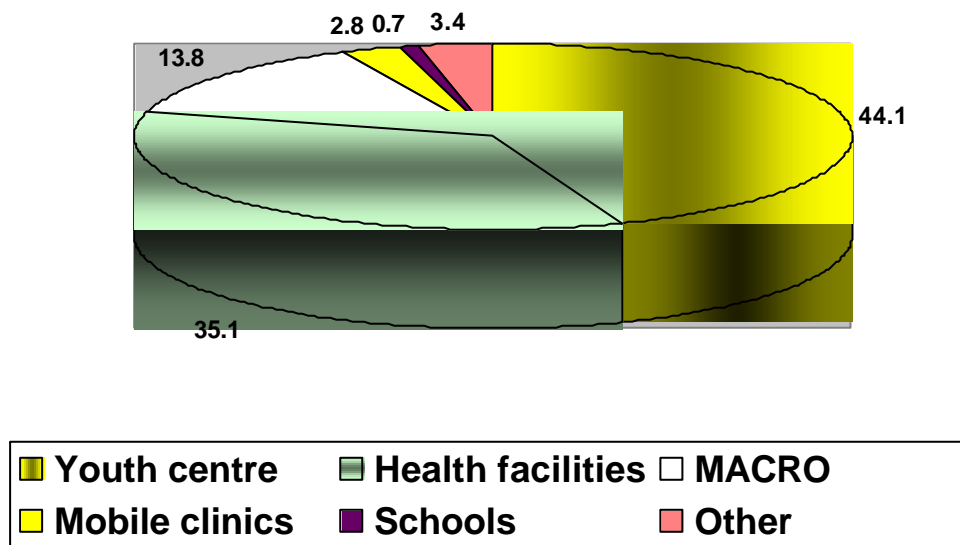


Figure 4.8: Sites where participants used VCT services

Youth centres are stand-alone places made specifically for young people where a full range of services and information are provided to young people (UNICEF, UNAIDS & WHO 2002:30). The service providers at these centres are young people. This relates to the earlier finding in section 4.3.1 of this dissertation where young people mentioned friends as primary sources of information on VCT. Friends are seen to be playing a major role in many activities, including the provision of information and services. However, there are few such centres in Malawi since it is costly to establish and maintain them. This means that many young people might be missing opportunities to get tested due to the lack of such youth specific services. The availability of a youth centre might therefore motivate more young people to go for VCT and greater efforts are required to make more of these services available throughout Malawi.

Several young people (35,1%; n=51) got tested at a health facility either a health centre or hospital. VCT services in Malawi are being scaled up through existing health facilities to ensure that more people have access to VCT services. Having these services therefore would motivate young people to go for VCT. However, there is still a need to ensure that the services provided at the health facility are attractive enough, welcoming, confidential and affordable that more young people can access these VCT services (UNICEF et al 2002:30). This is essential as health facilities are found everywhere in the country. As such, this would lead to having more young people going for VCT since they will have more ready access to and confidence in the services provided.

4.3.4 Reasons for going for VCT

The main reason stated by 93,1% (n=135) of the participants for going for testing was just to know their HIV status (Table 4.6), without elaborating on the needs to satisfy this apparent curiosity.

Table 4.6: Reasons for going for VCT

Reason for testing	Frequency	Percent
Just to know my status	135	93,1
Pressured by friends	5	3,4
Illness	2	1,4
Planning to get married or have a child	3	2,1
Total	145	100,0

Young people have realised the need for them to know their HIV status hence being motivated to go for testing. Knowing their status in this study can also be attributed to the fact that the majority of the participants were already sexually active as discussed in section 4.2.7 of this dissertation. These results support the findings of a study in Malawi where it was found that young people went for HIV testing primarily to know their HIV status (Yoder & Matinga 2004:26). It is

therefore critical to highlight the importance of knowing one's status during information sessions to young people since this finding shows that the desire to know their HIV status was what motivated many young people to go for VCT.

4.3.5 Sharing of HIV status results

Most of participants (79,3%; n=115) shared their HIV results with someone else. The people with whom they shared results varied from parents, friends and others. Details of persons with whom they shared these results are portrayed in Figure 4.9.

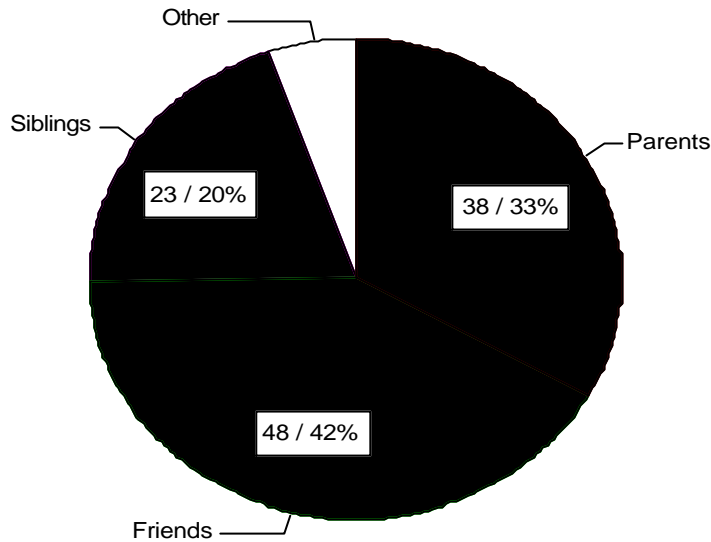


Figure 4.9: Persons with whom participants shared their HIV test results

Some young people (41,7%; n=48) mentioned friends as the persons with whom they shared their results. This finding might emphasise the confidence young people have in their peers. On the contrary, parents were not initially mentioned as a source of information for VCT in section 4.3.1 of this dissertation but the study findings show that 33,0% (n=38) of the participants shared their HIV test results with their parents. This might show that young people still have confidence in and would want to talk to their parents about such HIV issues. Consequently the need for programmes that empower parents to talk to their children cannot be overemphasised. However, disclosure of HIV status is not an

easy matter because of fear of stigmatisation and discrimination (Muula & Mfutso-Bengo 2005:293)

4.3.6 Changes in respondents' behaviours after VCT

Many participants (n=97; 66,9%) reported that they changed their behaviours after going for VCT. Table 4.7 indicates which changes took place. Two participants could not explain the actual changes in behaviour that took place, although they claimed that some behavioural changes had indeed taken place.

Table 4.7: Changes in behaviour after HIV testing

Behaviour	Frequency	Percent
Decided to abstain from sex	68	70,1
Decided to use condom always	16	16,4
Decided to stick to one partner	8	8,3
Decided not to have a sexual partner	3	3,1
Changed behaviour	2	2,1
Total	97	100,0

Table 4.8 shows that a large proportion of respondents (70,7%; n=58) who had sexual exposures stated they would change their behaviours whereas 60,0% (n=24) of the non-exposed young people saw no reason to change their behaviour. This could hinge on the decision for taking VCT in that most young

people did it simply because they wanted to know their HIV status, as discussed in section 4.3.4 of this dissertation. This finding appears to be consistent with the goals of the VCT campaigns emphasising that people who are exposed to HIV should visit VCT centres.

Table 4.8: Decision for behavioural change after VCT and exposure to sex

Ever had sex	Behavioral change after VCT				Total	
	Yes		No		N	%
	n	%	n	%		
Yes	58	70,7%	16	40,0%	74	60,7%
No	24	29,3%	24	60,0%	48	39,3%
Total	82	100,0%	40	100,0%	122	100,0%

As expected, there is strong statistical evidence suggesting a relationship between a decision to change one's behaviour after VCT and exposure to sex (See Table 4.8). This stems from calculations based on a two-way contingency table of asymptotic Pearson's Chi-square value that showed a p-value of less than 0,001, and which demonstrated a highly significant difference between exposure to sex and deciding to change behaviour after using VCT. Edited

computer generated output of the Chi-square tests performed are shown in Table 4.9.

Table 4.9: Chi-Square tests of the relationship between exposure to sex and decision to change behaviour after VCT

	Value	Degrees of freedom (df)	Asymptotic Significance (2-sided)
Pearson Chi-Square	10,640	1	,001
Continuity Correction	9,391	1	,002
Likelihood Ratio	10,559	1	,001
Linear-by-Linear Association	10,553	1	,001
Number of Valid Cases	122		

A number (46,9%; n=68) of the respondents mentioned abstinence as a behavioural change they adopted after going for VCT. These young people could therefore be used as role models to their peers to pass on information about going for VCT and their subsequent behavioural changes. Abstinence is promoted as one of the safest ways of avoiding HIV and young people are encouraged to do so. Information on the behaviour young people adopted after

going for VCT might motivate more young people to go for VCT because they should be able to see the benefits thereof.

The use of condoms was also mentioned by some of the participants as a behavioural change that they adopted after having gone for VCT. The findings of this study indicated that 11,0% (n=16) of the respondents used condoms to protect themselves from getting HIV after having used VCT services. The need to provide more information on correct and consistent condom use among young people, and ensuring that a conducive and supportive environment is created and maintained for young people to access and use condoms, cannot be overemphasised if the prevalence rates of HIV in Malawi are to be reduced.

4.3.7 Reasons why young people fail to go for VCT

Several reasons were identified as contributing to young people's non-utilisation of VCT services (see Table 4.10).

The main reason provided by most participants (88,9%; n=129) as strongly affecting young people's access to VCT was fear of HIV+ve results (77,9% definitely yes; n=113). Other reasons that participants felt had a major influence on young people's access to testing were feelings that they already had the virus (76,6%; n=101), lack of knowledge (70,3%; n=102) and being unsure about confidentiality issues (61,4%; n=89) as shown in Figure 4.10.

Table 4.10: Reasons why young people fail to use VCT services in Malawi

Reason for not going for testing	Definitely yes		Yes		No		Not at all	
	n	%	n	%	n	%	n	%
Fear of HIV positive results	113	77,9%	16	11,0%	12	8,3%	4	2,8%
Lack of knowledge about VCT	66	45,5%	36	24,8%	37	25,5%	6	4,1%
Uncomfortable with VCT sites	45	31,0%	39	26,9%	45	31,0%	16	11,0%
Peer pressure	29	20,0%	33	22,8%	56	38,6%	27	18,6%
Feel no need for testing	29	20,0%	37	25,5%	55	37,9%	24	16,6%
Fear of parents' reactions	18	12,4%	37	25,5%	82	56,6%	8	5,5%
Uncomfortable with providers	41	28,3%	42	29,0%	50	34,5%	12	8,3%
Unsure about confidentiality issues	58	40,0%	31	21,4%	37	25,5%	19	13,1%
Fear of stigma	46	31,7%	51	35,2%	34	23,4%	14	9,7%
Feel they are already HIV+ve	68	46,9%	43	29,7%	21	14,5%	13	9,0%
Other reason	0	0%	2	1,5%	117	88,0%	14	10,5%

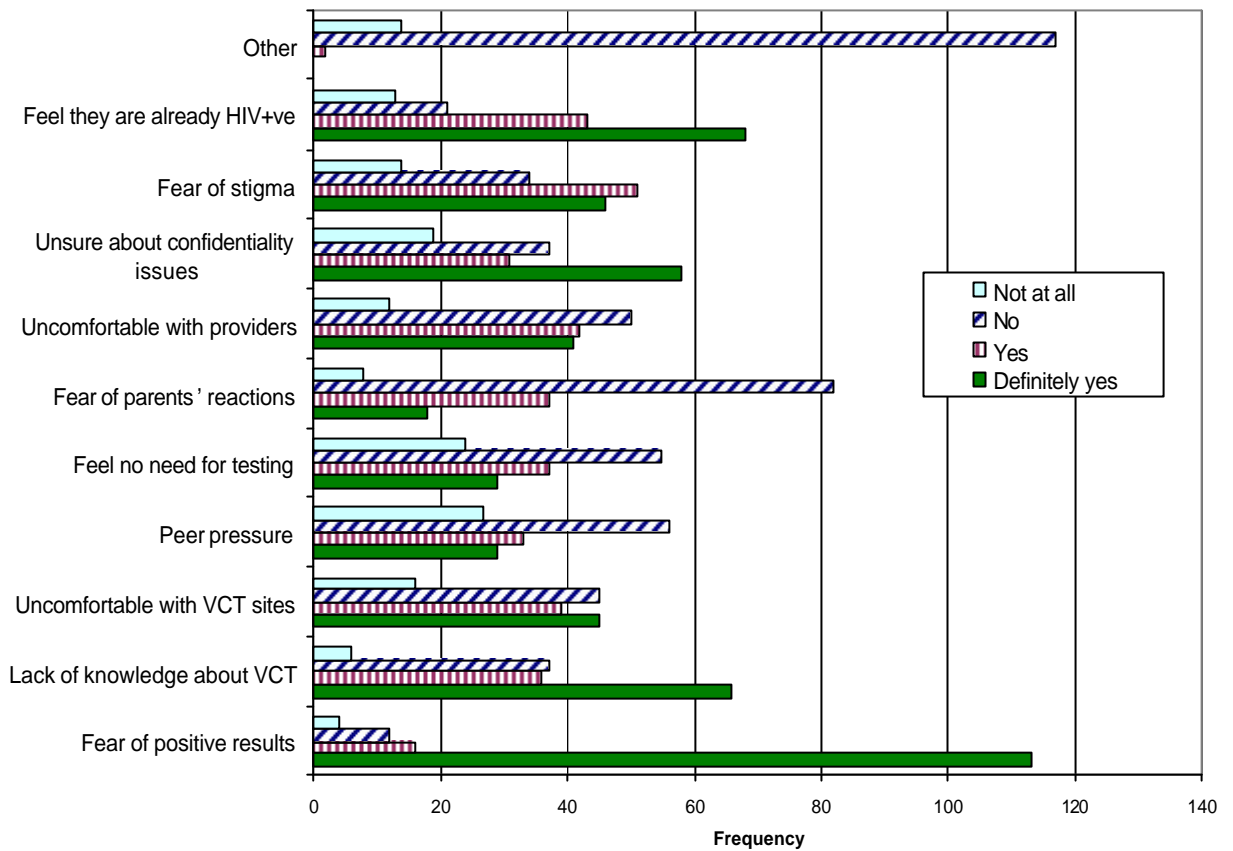


Figure 4.10: Factors causing young people's failure to use VCT services

These results support the findings of a study conducted in Malawi by Munthali et al (2004:27) on young people who had not gone for testing which reported that young people were not going for VCT because they feared receiving HIV+ve results. Similar findings were also reported in a study conducted in Zambia which revealed that 57,0% of boys and 53,0% of girls said they would like to have opportunities of going for HIV tests but the majority of them were not keen to

have HIV tests at that time, as they were worried that they might be HIV+ve (Baggaley 2001:34).

Young people in Malawi become sexually active at an age as early as 14 years as evidenced by the findings of this study in section 4.2.7. As a result, most of them feel that they are at risk of becoming HIV+ve, explaining their fears to go for VCT. However, the test results have shown that the rate of infection among this age group remains quite low at 9,0% among females and 2,0% among males compared to Malawi's national prevalence rate of 14,4% (Hauya 2006:6). Therefore, informing the young people that there are low HIV infection rates among them, might motivate them to go for VCT since they might have more confidence that they would be HIV-ve.

Related to this fear factor, is the finding of this study that young people who felt that they might already have the virus did not need to go for VCT to confirm their suspicion. Lack of information about VCT also affects young people's access to VCT. This therefore requires that intensive information be provided to young people to make them realise the importance of knowing one's HIV status and to empower them to have hope that they might still be HIV-ve despite their sexual encounters.

4.4 VOLUNTARY COUNSELLING AND TESTING SERVICES

Participants in the study were asked to give their opinion on a number of VCT-related issues and services. Participants first expressed their impressions regarding certain characteristics of VCT services. Secondly, participants stated their approval or disapproval of personal and professional qualities of service providers at VCT sites. Thirdly factors of VCT sites such as closeness to a participant's home, length of waiting time at the site, knowledge of providers and others were assessed. Fourthly, participants expressed their satisfaction with services received. Fifthly, respondents expressed their preferences where to receive VCT services. Lastly, participants' approval of relevant interventions that are deemed to attract young people toward VCT was investigated.

The following sections give the results of the analysis of these issues. It is to be noted that whereas responses are outlined in four ordered categories ranging from strong approval (response of "definitely yes") to strong disapproval (response of "not at all"), the displayed results group together the two responses of "definitely yes" and "yes" into one.

4.4.1 Characteristics of the VCT sites

The most common requirements of a VCT site included privacy, youth providers, short waiting times and cleanliness of the site (Table 4.11).

Table 4.11: Requirements of a VCT site

Characteristic	Definitely yes		Yes		No		Not at all	
	n	%	n	%	n	%	n	%
Privacy	113	77,9%	7	4,8%	23	15,9%	2	1,4%
Adult providers	54	37,2%	37	25,5%	45	31,0%	9	6,2%
Young providers	104	71,7%	25	17,2%	11	7,6%	5	3,4%
Short waiting time	68	46,9%	37	25,5%	28	19,3%	12	8,3%
Cleanliness of the site	77	53,1%	41	28,3%	15	10,3%	12	8,3%
No linkage to a health facility	31	21,4%	44	30,3%	52	35,9%	18	12,4%
People should not know that one has gone for VCT	45	31,0%	46	31,7%	40	27,6%	14	9,7%
Other	3	2,3%	4	2,8%	117	88,0%	9	6,8%

The results in Table 4.11 show that most participants (82,7%; n=120) mentioned privacy and having young providers (88,9%; n=129) as most important requirements of a VCT site (see section 4.3.3). This is confirmed by this study where more respondents (44,1%; n=64) went for testing at a youth centre. A youth centre is believed to ensure privacy because young people go to the centre for various purposes and one would not know that someone has gone there specifically for testing.

Having young providers kept on re-appearing as an important requirement for a VCT site in this study as one factor that would motivate young people to go for VCT (88,9%;n=129). It is therefore imperative that where VCT services are provided, either at health facilities or stand alone sites, that young health care workers or youth counsellors should be available to provide the service to their peers.

Cleanliness of the service provision site (81,4%; n=118) and short waiting times (72,4%; n=105) also attract young people to access the VCT services. As such, if more young people are to be motivated to access VCT, there is a need to make the environment clean and attractive. Special interventions also need to be put in place to ensure that waiting times to access the VCT services are decreased.

All individual Pearson's Chi-square and Likelihood ratio tests of relationships carried out to explore the presence of any relationship between sex of

respondent and the characteristics of VCT sites as outlined in Table 4.11 yielded asymptotic significance values of greater than or equal to 0,05. Similar results were revealed in investigating relationships between ages of participants and the requirements of VCT sites. This suggests that there is no significant difference between males and females with respect to their approval of each requirement (see Table 4.11) on one hand and ages of participants on the other hand. In general, it can be concluded that sex or age are not influencing factors in participants' perceptions toward the outlined characteristics of VCT sites. This further implies that young people have similar feelings towards what attracts them to a facility. As such, no specific intervention is required to attract a particular group of young people to access VCT. General strategies would cater for all the age groups and for both sexes.

4.4.2 Qualities of a counsellor

All young people (100,0%; n=145) preferred to have counsellors with a welcoming attitude, who are non judgmental and who provide relevant information about HIV (see Table 4.12).

Table 4.12: Qualities of a counsellor

Qualities of counsellor	Definitely yes		Yes		No		Not at all	
	n	%	n	%	n	%	n	%
Welcoming attitude	139	95,9%	6	4,1%	0	0,0%	0	0,0%
Provided information about HIV	110	75,9%	28	19,3%	4	2,8%	3	2,1%
Non-judgmental	95	65,5%	26	17,9%	15	10,3%	9	6,2%
Make one feels comfortable	80	55,2%	32	22,1%	15	10,3%	18	12,4%
Young	78	53,8%	41	28,3%	15	10,3%	11	7,6%
Asking questions	70	48,3%	56	38,6%	14	9,7%	5	3,4%
Respect for young people	84	57,9%	38	26,2%	12	8,3%	11	7,6%
Assured of confidentiality	76	52,4%	22	15,2%	21	14,5%	26	17,9%
Referral to other places	56	38,6%	41	28,3%	29	20,0%	19	13,1%
Knew what they were doing	71	49,0%	48	33,1%	11	7,6%	15	10,3%
Adults	43	29,7%	54	37,2%	37	25,5%	11	7,6%
Not known to young people	37	25,5%	47	32,4%	44	30,3%	17	11,7%
Other	2	1,4%	1	0,7%	123	91,1%	9	6,7%

The results from Table 4.12 show that a welcoming attitude of the service provider is definitely an important characteristic of a counsellor (95,9%; n=139) that could motivate more young people to access VCT. These results support the findings of a study conducted in Malawi which revealed that young people did not access VCT services due to worries about confidentiality, attitudes of service providers and fears that the results would be shared with their parents without the young people's consent (Munthali et al 2004:27). This goes along with non judgmental attitudes of the counsellors which young people also considered to be a very important requirement. Measures to make the counsellors more youth friendly therefore need to be put in place in order for more young people to access VCT services. A youth friendly service provider needs to be welcoming and non judgmental (NYCOM 2001:29), as confirmed by the participants in this study.

Information provision by counsellors was also mentioned in this study as being a very important characteristic by most (95,2%; n=138) of the participants. Young people have confidence in counsellors hence would like to get more information, which is considered to be accurate by them. More time therefore needs to be made available by the counsellors to conduct sessions that will provide more information to young people to address the barrier of lack of information aggravating young people's lack of access to VCT services.

4.4.3 VCT site factors affecting young people's access

The results of the study show that closeness to participants' homes and long waiting times at VCT sites, influence young people's access to VCT services. Only two-thirds (65,6%; n=95) of the young people stated closeness of the site to their homes was a negative factor to access VCT services. For long waiting times as many as 77,2% (n=112) expressed that it might have limited young people's access to VCT services. The detailed results are displayed in Table 4.13.

Table 4.13: Factors associated with a VCT site's accessibility to young people

Factor	Definitely yes		Yes		No		Not at all	
	n	%	n	%	n	%	n	%
Closeness to home	81	55,9%	14	9,7%	47	32,4%	3	2,1%
Many people go there	52	35,9%	40	27,6%	51	35,2%	2	1,4%
Long waiting time	73	50,3%	39	26,9%	23	15,9%	10	6,9%
Knowing the providers	39	26,9%	44	30,3%	49	33,8%	13	9,0%
Linkage with health facility	24	16,6%	41	28,3%	58	40,0%	22	15,2%
VCT specific site	37	25,5%	27	18,6%	67	46,2%	14	9,7%
Other	1	0,7%	5	3,7%	116	85,3%	14	10,3%

These results suggest that some young people fail to access services which are too close to their homes, probably due to fears that their parents might know that they had gone for testing because their parents might know the service providers at sites close to their homes. Therefore, providing the services at places which are not close to young people's homes might motivate more young people to access the VCT services. This could be done through outreach service provision to places where young people meet. These outreach sites could ensure that young people meet service providers whom they do not know, enhancing their confidence to access the VCT services.

4.4.4 Aspects young people disliked about the counselling process

The results of the study show that young people (71,1%; n=103) generally liked the counselling process except for a few (24,1%; n=35) who indicated that the counselling process was definitely too long. Details are shown in Table 4.14.

Table 4.14: Aspects young people disliked about the counselling process

Issues	Definitely		Yes		No		Not at all	
	yes		Yes		No		Not at all	
	n	%	n	%	n	%	n	%
Counselling process too long	35	24,1%	7	4,8%	99	68,3%	4	2,8%
Not at all required info for providers	30	20,7%	31	21,4%	80	55,2%	4	2,8%
Counselling process too short	22	15,2%	17	11,7%	91	62,8%	15	10,3%
No demonstrations on condom use, testing	24	16,6%	40	27,6%	60	41,4%	21	14,5%
Other	0	0,0%	10	7,5%	116	86,6%	8	6,0%

4.4.5 Young people's preference of a VCT site

The results (see Table 4.15) show that many young people (90,4%; n=131) would prefer to get tested at government facilities, MACRO sites (86,2%; n=125) and youth centres (85,5%; n=124).

Table 4.15: Preference for VCT site

Testing site	Definitely yes		Yes		No		Not at all	
	n	%	n	%	n	%	n	%
Government health facility	110	75,9%	21	14,5%	10	6,9%	4	2,8%
Youth centre	95	65,5%	29	20,0%	17	11,7%	4	2,8%
School	51	35,2%	27	18,6%	55	37,9%	12	8,3%
Mobile VCT sites	49	33,8%	41	28,3%	39	26,9%	16	11,0%
MACRO	97	66,9%	28	19,3%	13	9,0%	7	4,8%
Private clinic	47	32,4%	33	22,8%	49	33,8%	16	11,0%
Other	0	0,	4	3,0%	115	87,1%	13	9,8%

A number of Pearson's Chi-square tests were carried out to find whether there was any significant association between each of the listed preferred places for testing and the residential area (urban, semi-urban and rural) of the participants. Results of the three statistical tests are shown in Table 4.16.

Table 4.16: Results of statistical tests of association between some preferred testing places and areas where participants usually resided

Type of statistical test	Residential area and preference of :								
	Government Health Facility			Youth Centre			Mobile VCT		
	Value	df	Sig.	Value	df	Sig.	Value	df	Sig.
Pearson Chi-Square	9,348	6	0,155	15,405	6	0,017	24,512	6	0,000
Likelihood Ratio	10,209	6	0,116	15,788	6	0,015	24,496	6	0,000
N of Valid Cases	145			145			145		

* Asymptotic significance (p -value, 2-sided)

Please note that the degrees of freedom (df) are calculated as $(n-1) \times (n-1)$ for an $n \times n$ contingency table of the cross tabulation of n levels of one variable and n levels of the other variable. Hence for the 4 levels of the responses of each of the variables shown in Table 4.16, for the four optional responses, and the 3 levels of responses for the residential area, namely urban, semi-urban and rural, degrees of freedom are calculated as $(4-1) \times (3-1) = 6$. The displayed asymptotic significance values or probably values of the association, also known as p-values are based on 95% confidence levels (giving a significance level of $\alpha=0,05$). A p-

value of less than 0,05 is said to be indicative of a significant difference in the associations of each of the levels of one variable with those of the other variable. All tests are based on the null hypothesis that there is no difference between levels of residential areas in association with specific responses of participants.

It can therefore be deduced that evidence of a relationship between residential areas and preferred places for testing favour youth centres and mobile VCT. In fact the association between residential area and mobile VCT is significant (p-Value < 0,001) that it can be concluded that there was evidence suggesting that members differed with respect to their areas of usual residence and their preference of mobile VCT services. This finding warranted critical examination of the proportions of participants' preference of VCT sites by residential areas. It was then determined that more participants from the semi-urban areas (68,9%; n=31) and rural areas (61,4%; n=27) preferred mobile VCT services whereas more participants from urban areas (57,2%; n=32) do not prefer mobile VCT. This might be the case since VCT services are widely available in the urban areas hence people have a wide choice of places to go to for testing. On the other hand, VCT services are not widely available in semi-urban and rural areas hence the need to bring the services closer to young people through mobile VCT services.

There was a significant relationship between youth centre and residential area (Pearson's Chi-square: α 0,01; 6 df). More young people residing in the semi-urban areas (77,8%;n=35) and rural areas (72,7%;n=32) preferred to get tested at youth centres compared to those from the urban areas. This might happen for the same reason that VCT services are not widely available in rural and semi-urban areas. However, generally the findings show that a youth centre is still preferred by more young people in the urban areas hence it is a strategy that can be promoted in all residential areas.

The participants' preference for government health facilities (90,4%;n=131) shows that many more people can access VCT since most of the health facilities in Malawi are providing VCT services. However, there is a need to ensure that young people's requirements of VCT sites and counsellors met (as discussed in section 4.4.1 & 4.4.2 of this Chapter) so that more young people are motivated to access the VCT services at government health care sites. Despite the fact that more participants (44,1%; n=64) got tested at youth centres, the preference for government facilities was high among young people from all residential areas that gave rise to the question as to why this difference should occur.

MACRO which is a stand alone VCT site was mentioned as a second preferred place for young people (86,2%; n=125) to go to for VCT. This emphasises the need for stand alone VCT services which could motivate young people to go for VCT.

The results of this study generally show that young people are ready to get tested from various service delivery points as long as they provide youth friendly services. In addition, interventions targeting those in the rural areas should ensure that mobile VCT services are available due to the general lack of health facilities in rural areas.

4.4.6 Interventions that could enhance young people's utilisation of VCT services

The research results indicate that more information on VCT should be given to young people (99,3%; n=144), more young VCT providers (84,1%; n=112) should be used and young people should talk to their peers (84,1%; n=122). These were the highly recommended interventions that would increase young people's access to VCT (see Table 4.17).

Table 4.17: Interventions that will make young people go for VCT

Intervention	Definitely		Yes		No		Not at all	
	yes							
	n	%	n	%	n	%	n	%
Providing more VCT info	142	97,9%	2	1,4%	1	0,7%	0	0%
Bring testing to schools	47	32,4%	47	32,4%	38	26,2%	13	9,0%
Use more young VCT providers	96	66,2%	26	17,9%	14	9,7%	9	6,2%
Sensitise parents on testing need	67	46,2%	28	19,3%	36	24,8%	14	9,7%
Have young people talk to peers	94	64,8%	28	19,3%	8	5,5%	15	10,3%
Have special room for young people	71	49,0%	33	22,8%	31	21,4%	10	6,9%
Have special day for young people at site	42	29,0%	34	23,4%	57	39,3%	12	8,3%
Deploy youth friendly providers	66	45,5%	36	24,8%	13	9,0%	30	20,7%
Conduct mobile VCT provision	53	36,6%	40	27,6%	27	18,6%	25	17,2%
Other	1	0,8%	4	2,9%	116	89,2%	9	6,9%

The results suggest that young people feel that using their peers to provide VCT services as well as talking to each other might motivate more young people to access VCT. It is therefore important that young people are involved in all activities related to VCT, including information provision, service provision and follow up visits/services. Having a special room specifically for counselling young people was also an important strategy that would motivate young people to go for VCT (71,8%; n=104). This could be a big a challenge in Malawi where health facilities already have limited space within which to offer numerous types of services.

Pearson's Chi-square tests indicate that bringing testing to a school had a significant difference with regard to residential area (Pearson's Chi-square test: $\alpha < 0,001$; 6 df). This could imply that there was a strong relationship between where a young person resided and his/her acceptance of testing carried out at schools. Whereas more rural young people would demand testing done at schools, urban and semi-urban young people would prefer otherwise.

Having young people talk to their peers also differed significantly in relation to residential area (Pearson's Chi-square test: $\alpha < 0,05$; 6). Whereas more young people living in urban and semi-urban areas would prefer that young people talked to their peers in VCT centres, more rural young people did not welcome this idea. In this context, there is some evidence of a relationship between the

area of residence and young people's levels of perception of having their peers talk to them about HIV/AIDS at VCT centres.

Similar results of relationships are also seen in the young people's differences in their perceptions of having a special day at VCT sites and youth-friendly workers. Some weak relationship (p -value = 0,057) exists between having special days at VCT sites and age groups. Fewer participants (48,4%; $n=31$) in the older age groups were more particular about the need for a special day at VCT sites than the younger age groups (58,6%; $n=17$). Only those aged between 18–21 years felt having a special day would enable more young people to utilise VCT services.

There was also some strong relationship between providing more information on VCT and age (p -value = 0,042, 4 df). The older age group 18-25 years wanted more information to be provided at VCT centres while the younger age group did not see a need for more information as being important. Almost all (99,0%; $n=144$) of the young people of all ages felt that if more information would be provided to young people, more of them would go for VCT.

Generally, the results show that a lot of organisation needs to be done at health facilities to make them attractive and motivate more young people to access VCT services. All the strategies seem to have some impact on young people's motivation to access services but the most important ones were provision of

information, having young VCT providers, having young people to talk to, having a special room, deploying youth friendly providers and sensitising parents to VCT. If all these strategies were to be put in place, more young people would be motivated to access VCT services in Malawi.

4.5 CONCLUSION

It has been highlighted in this chapter that there are various factors that motivate young people to use VCT services. More females in the rural and semi-urban areas are accessing VCT services than those from the rural areas. The majority of the young people are engaging in sex, exposing them to HIV risks, hence their sexual activities motivated them to go for HIV testing. Exposure to education provides young people opportunities to get more information on HIV and VCT, motivating more to go for VCT. The prime sources of VCT information for most of young people were friends, radio and school and most of the young people made personal decisions to go for HIV testing. Most young people got tested at a youth centre and health facility and the main reason for going for VCT was the desire to know their HIV status. On the other hand, one of the major reasons why some young people were not going for testing was their fear of being found HIV+ve. Most young people would prefer to get tested at a Government health facility as long as it fulfils the requirements for young people to access the services. These include having youth friendly health service providers, having young people provide the services, a clean environment that provides privacy and having a

special room for young people. These conclusions will be contextualised within the HBM major tenets in chapter five.

The next chapter will present the conclusions, limitations and recommendations of this study as well as proposed areas for future research.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The main purpose of the study was to explore and describe factors that motivate young people aged 14–25 years to access VCT services in Malawi. Furthermore, factors hindering access to VCT services in Malawi were also identified and described. This information has been used to recommend ways in which VCT services in Malawi could become more accessible to more young people aged 14-25. The conclusions, based on the research results discussed in Chapter 4 of this dissertation, will be used to answer the research questions which were formulated in Chapter 1 as follows:

- What are the reasons why young people are going for VCT in Malawi?
- What are some of the factors that are hindering young people's access to VCT services in Malawi?
- What could be done to ensure that more young people access VCT services in Malawi?

5.1.1 Objectives

The objectives were formulated in terms of the HBM's major tenets addressing participants' perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy.

The objectives of the study were evaluated to determine whether they have been attained. Each objective will be listed and the conclusions given in relation to that specific objective.

- To identify reasons why young people go for VCT in Malawi

The results in the study have shown that most young people went for VCT principally because they wanted to know their HIV status. There are other factors that contributed to their motivation to access VCT services. These included the knowledge level of the participants where the study revealed that the education level of the participants contributed to accessing VCT services by young people. All the participants who were interviewed had attended school to a certain level and those in secondary school were in the majority (80,0%; n=116). The site where young people accessed VCT services also influenced their access to these services. Young people got motivated to go for VCT to sites that ensured privacy, where young people were providing the VCT services, where the service providers were youth friendly and where confidentiality was ensured. Consequently, most of the participants in the

study got tested at a youth centre (44,1%; n=64) while 35,1% (n=51) got tested at a government facility and 13,8% (n=20) at MACRO.

- To identify possible barriers experienced by young people in accessing VCT services in Malawi

The study has shown that young people fail to access VCT services due to various factors. The most common reason mentioned by most of the young people (88,9%;n=129) was the fear of getting HIV+ve results and fearing that they might already be HIV+ve (76,6%;n=101). Other reasons included the location of VCT sites which might not provide privacy especially when these sites are close to young people's homes (65,6%; n=95) , long waiting times at the VCT sites to access the services 77,2% (n=112), being unsure about confidentiality by the service providers (61,4%; n=89) and a lack of adequate information about VCT (70,3%; n=102).

- To identify strategies that would promote VCT access by young people in Malawi

The study has shown that young people would like to have special interventions done to ensure that more young people get motivated to access VCT services. Such interventions included providing more information to young people on VCT (99,3%; n=144), involvement of young people in both information and service provision as peer educators (84,1%; n=112) and peer counsellors, the establishment of a special room

in each health facility for young people (71,8%; n=104), ensuring the availability of youth friendly health providers (70,1%;n=102) and the provision of VCT services at youth centres (85,5%; n=124), mobile VCT clinics (64,2%; n=93) and schools (64,8%; n=94). Most young people from the rural areas (72,7%;n=32) and semi-urban areas (77,8%;n=35) preferred having VCT services through mobile clinics.

5.2 CONCLUSIONS BASED ON THE HEALTH BELIEF MODEL TENETS

Several conclusions have been made in this study based on the research results that were analysed in Chapter 4. These findings have been contextualised within the HBM's tenets.

5.2.1 Perceived susceptibility

The findings of the study revealed that young people in Malawi, who participated in this study, perceived themselves as being at risk of getting HIV. This is evident in the study where the majority of the participants (93,1%;n=135) went for HIV testing to know their HIV status. In addition, 60,7% (n=74) of the participants had indulged in sexual activities hence realising that they were at risk of getting HIV and thus decided to go for VCT. The results also showed that 76,6% (n=101) young people were not going for HIV testing because they felt they might already be HIV+ve and they did not see the need for any tests to confirm their suspicions of being HIV+ve.

5.2.2 Perceived severity

The results showed that young people realised the severity of their risk to HIV. This was evident in the study where 77,9% (n=113) of the young people made independent decisions to go for HIV testing. The mere fact that the participants of this study had gone for testing expresses young people's feeling of how they perceived the severity of the HIV problem and that they might also be affected.

5.2.3 Perceived benefits

Young people in this study got information on VCT primarily from friends (29,7%;n=42), the radio (27,6%;n=40) and schools (27,6%;n=40). As many as 55,2%(n=80) of the respondents belonged to youth clubs where issues such as HIV and VCT were discussed. As such, young people were able to realise the benefits of going for testing and went for HIV testing. The young people believed in the efficacy of the advised actions to reduce HIV risks by knowing their HIV status. In addition, 70,7% (n=58) of the young people who had had sexual encounters, changed their behaviours after learning their HIV status. The main change of behaviour was in terms of abstaining from sex (70,1%;n=68) and using condoms (16,4%;n=16).

5.2.4 Perceived barriers

Young people perceived some barriers which prevented them from accessing VCT services. One major barrier was the complexity of the desired behaviour of going for HIV testing where the majority (88,9%;n=129) of the participants mentioned that young people were not going for VCT due to fears of being found HIV+ve. This was compounded by a lack of adequate knowledge on VCT among young people. Some service and service provider related factors also acted as barriers to young people's access to VCT. These included young people's feeling that service providers would not maintain confidentiality (61,4%; n=89), while some felt uncomfortable with the service providers and the VCT sites in general. Closeness of the VCT sites to their homes (65,6%; n=95) and long waiting times (77,2%;n=112) to access VCT services also acted as barriers to access VCT services.

5.2.5 Cues to action

Young people suggested several interventions that could motivate more young people to go for HIV testing. VCT sites should ensure young people's privacy (82,7%;n=120) and the waiting times should also be short (72,4%;n=105). Having a special room (71,8%;n=104) for young people to access VCT services would motivate more young people to use these services. Young people liked to access VCT services in clean environments (81,4%;n=118) which were attractive and comfortable. The services should be provided through various points like youth centres, Government facilities,

mobile clinics, stand alone VCT sites and MACROS. The service providers should be young people that are youth friendly.

Having these measures in place would enhance young people's motivation to access VCT services since it would give them the confidence that they could access the services without encountering barriers.

5.2.6 Self-efficacy

Young people mentioned that more information on VCT should be given to them (99,3%; n=144), more young VCT providers (84,1%; n=112) should be used and young people should talk to their peers (84,1%; n=122). By having more information, young people would be able to make informed decisions to take required actions, in this case in going for VCT. The respondents mentioned that friends were critical in ensuring that peers got the confidence to go for testing. As such, some of the young people who had already gone through VCT, could act as motivators to their peers. Having young role models who had gone through the experience of going for VCT coupled with the availability of VCT information would increase young people's likelihood to reach self efficacy.

5.3 LIMITATIONS OF THE STUDY

The limitations that were identified during the course of the study included that:

- The research results might be limited to the three sites where the study was conducted since the sample was small. However, the sample comprised young people from three regions of Malawi representing urban, semi-urban and rural residential areas.
- The researcher ended up interviewing 145 participants. This was due to the fact that getting young people who had utilised VCT services was not easy since getting tested is still a sensitive issue in Malawi. As such, young people, especially girls, who had gone for testing were not coming forward easily.
- All the participants in this study had attended school hence the results might thus not be generalised to illiterate young people.

5.4 RECOMMENDATIONS FOR IMPROVING ACCESS TO VCT SERVICES BY YOUNG PEOPLE IN MALAWI

Improvements in the access to VCT services by young people in Malawi, based on the research results, might be enhanced if the following recommendations were implemented. It is recommended that

- Young people should be actively involved in the provision of VCT information and services to their peers. Their involvement should be at all levels that is at community, health facility, youth centre as well as youth related policy development levels.

- More information on VCT should be provided to young people through various media with special focus on the use of peer educators, youth radio programmes and schools as important sources of information.
- Youth clubs with well trained young people providing VCT information should be established throughout Malawi to ensure that young people have direct sources of accurate information which would motivate them to go for VCT.
- Efforts should be put in place to make existing health services more youth friendly by ensuring that wherever possible special rooms for young people are made available at health facilities and that the VCT service providers are trained on how to make their services attractive to young people.
- Mobile VCT services should be conducted especially in the rural areas and semi-urban areas to ensure that young people have access to these services in places where VCT services are not yet provided in their health care centres. This would be an interim measure while awaiting the provision of VCT services in the health centres.
- Young people should have a choice of where they would like to get tested hence need to have various models of provision of VCT services available. Wherever resources are available from Government or non-governmental organisations, youth centres should be constructed and VCT should be one of the services provided. Government should ensure that all the public health facilities are providing VCT services and also provide support to mission and private hospitals to be able to provide VCT services. This support could be in the form of training, provision of HIV test kits and

related supplies and technical support. This would ensure that VCT services are widely available for young people to access and utilise.

- Information on the provision of youth friendly health services should be incorporated in health professionals' training curricula to ensure that service providers handle young people respectfully by the time they qualify, rather than waiting for in service education, to master this competency.
- Parental involvement in the provision of SRH and HIV information to young people should be strengthened by empowering parents with knowledge and skills to do so. This could be done through the sensitisation of parents on VCT and their role in providing SRH and HIV information to their children.
- Those young people that have gone for VCT should be actively involved as peer motivators and role models to their peers. This should include both those who test HIV+ve and HIV -ve who should come out in the open about their results.
- Statistics of young people who have gone for testing and showing the results that most of the young people are HIV -ve should be disseminated to young people and throughout Malawi. This will ensure that more young people could hope that there are higher chances that they might be HIV -ve, hence get more motivated to go for VCT.

5.6 RECOMMENDATIONS FOR FURTHER STUDIES

The findings of this study suggest that future researchers could investigate the following:

- Duplication of this study in other geographic areas prior to generalisation of these research results to all the young people in Malawi.
- Duplication of the same study targeting young people who had never gone to school.
- Investigating the role of parents in motivating young people to go for VCT.
- Further investigate the perceptions of young people towards accessing VCT services from health facility versus youth centres and mobile services.
- Identify and implement interventions that could be put into place to have more illiterate young people access VCT services.
- Explore the impact of VCT on behavioural changes among young people
- Conduct research about the knowledge, attitudes and perceptions of traditional healers concerning VCT in an attempt to get their support for VCT, especially among young people in Malawi.
- The knowledge, attitudes and perceptions of TBAs should also be investigated in Malawi and education should be offered so that the TBAs could cooperate by referring young mothers for VCT.
- Qualitative research should be conducted to determine young people's lived experiences of utilising VCT services in Malawi.

5.6 CONCLUSIONS

The study revealed that young people generally get tested because they would like to know their HIV status. One of the contributing factors may be exposure to sexual encounters predisposing them to HIV risks. This applies to all young people regardless of sex, marital status, age or residential status. Most young people are not going for testing because of fears of being diagnosed HIV+ve and a feeling that they might already have the virus. Young people get motivated to go for VCT in places where their peers are providing the services and where health providers have a welcoming attitude and where privacy is ensured. Young people would therefore like to get VCT services in places where special interventions to attract them to the facility are put in place. These include providing services in youth centres, having young providers, having special rooms for young people in the health facilities and having youth friendly health providers in a clean environment.

5.7.1 FINAL CONCLUDING REMARKS

The importance of enabling more young persons to access VCT services in Malawi cannot be overemphasised in the struggle to arrest the rapid increased prevalence of this disease in Malawi. Not only will the young persons themselves benefit by VCT, but also their children and their friends and family. The essence of the essential nature of this research can be best summarised in the words of other researchers who conducted HIV/AIDS research in another part of southern Africa, who emphasised: “The HIV/AIDS epidemic presents special challenges and new frontiers for public health

intervention and research. In the current situation where absolute cure for the disease is not available and when infection results in eventual death, reducing the spread of HIV/AIDS through prevention must be the focus of our efforts. An assessment of the current effort to reach and educate adolescents is a necessary first step. An understanding of adolescents ... is essential for designing and implementing HIV/AIDS prevention programs” (Buseh, Glass, McElmurry, Mkhabela & Sukati 2002:533).

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